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Women, Work, and Wellness

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Edited by

Virginia Carver and Charles Ponée

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Patricia Badiet
Paula Bennett
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DEDICATION

This book is dedicated to all Employee Assistance Programmers, managers, union representatives, and health care professionals who strive in their day-to-day work to ensure that women workers—as well as their male counterparts—are given every opportunity to experience health, wellness, and a sense of personal fulfilment at work.

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Patricia Badiet, MSW, is a professional social worker and has been an advocate on women's addictions issues for more than a decade. As one of her major contributions to the field, she coordinated one of the first provincial consultations on women and addictions. More recently, she has directed a range of health promotion initiatives for employees within the context of an Employee Assistance Program in a federal government agency.

Paula Bennett, MSW, was appointed Director of Research and Policy at the Women's Bureau of Labour Canada in 1984. Since January 1989, she has assumed the responsibilities of Director General of the Bureau. Before joining the Women's Bureau, she held a number of positions at Employment and Immigration Canada, including that of Senior Advisor in the Policy and Legislation Development Directorate of the Insurance Branch. Her first working years were spent in the social welfare field.

Christine Bois, MASc, is a Centre Director with the Addiction Research Foundation working in a rural setting. She has been involved with the issue of women and substance abuse since 1978 when she was a staff member with Canada's first women's treatment program. One of her major concerns is the development of appropriate addictions services for rural women.

Virginia Carver, PhD, has worked in the addictions field for 16 years. She is currently a community consultant and Acting Eastern Ontario Treatment Services Coordinator with the Addiction Research Foundation. Her particular interest is the development of innovative addictions treatment services for women. More recently she has been involved with increasing the awareness of workplace leaders concerning women's health issues.

JEANETTE COCHRANE, BA, is a mental health consultant doing research on stress, particularly occupational stress. She also writes, lectures, and holds seminars on stress.

CAROL-ANN CURNOCK, MEd, has a broad background in the marketing and human resources areas. As an EAP consultant with the ARF, she was the Foundation's expert on how workplace health programs could best address women's needs. She is currently Manager of Employee Services for the Canadian Imperial Bank of Commerce, Toronto.

MARGRIT EICHLER, PhD, is a leading Canadian sociologist who focuses on the changing conditions of the Canadian family and, in particular, their effect on women and social policy. She is well known for her research, authorship, and commentary on Canadian families.

SUSAN GILMAN, MSW, a professional social worker and educator, has provided leadership in Canada on the very special issues of child abuse and spousal assault. She is currently working on an innovative child sexual abuse training and policy program for youth-serving organizations—a joint endeavor between Health and Welfare Canada and the Canadian Council on Children and Youth.

KATHLEEN HUMPAGE, MPA, is a Policy and Program Analyst with the Women's Bureau of Labour Canada. She holds a BA from Queen's University and m aster's degree in Public Administration from Carleton University, and is completing work on her PhD dissertation.

JANICE INNISS, BScN, CCOHN, is an occupational health nurse who currently directs health services and the Employee Assistance Program at the Canadian Bank Note Company Ltd., Ottawa. She is a member of the national executive of the Canadian Council for Occupational Health Nurses Inc., and her primary interest is to provide occupational health services that contribute to the health and well-being of all employees and to promote individual and organizational behaviors that support a healthy lifestyle and a safe and productive work environment.

MARY K-HUGESSEN, MSW, is a professional social worker who is currently employed by the Anglican Diocese of Ottawa as Director of the Pastoral Centre. She has extensive experience in counselling, particularly with substance-abusing clients. More recently she has given community leadership in the development and coordination of addictions services. She is particularly concerned with the development of appropriate services for women.

HELEN LEVINE, MSW, has been a leading Canadian activist in women's issues for many years. As professor of social work at Carleton University and a committed feminist, her work at the School has focused on the development of a feminist perspective in relation to the theory and practice of social work. Since her retirement, she has continued to be involved in feminist counselling and the women's movement.

LYNN LIGHTFOOT, PHD, has carried out research and written numerous books and scholarly articles on addictions. In particular her leadership has been directed at substance abuse and the criminal justice system and the development and evaluation of models of assessing and referring chemically dependent persons. She currently directs ARF's programs in Eastern Ontario.

COLLEEN LUNDY, PHD, teaches at the School of Social Work at Carleton University. She has had a long history of involvement as a practitioner, reseacher, and educator in the area of women and chemical dependency.

JOAN MARSHMAN, PHD, schooled as a medicinal chemist, is a researcher and author who is associated with the "Marshman Report," which established a direction for the development of addiction treatment services across Ontario. She was President of the Addiction Research Foundation from 1981 to 1989 and will shortly be undertaking study and research in the area of health economics. As a member and as chair of the Federal-Provincial Advisory Committee on Alcohol and Other Drug Problems, she helped develop a national drug strategy for Canada.

DAVID NITKIN is an author and social commentator on health, social, and managerial issues at the workplace. Concerned with workplace ethics, he is president of Ethiscan Canada Ltd., which operates a one-of-a-kind research house on the social performance of 1,500 Canadian companies. In addition, he is President of The Canadian Clearinghouse for Consumer and Corporate Ethics and a regular contributor to the *Corporate Ethics Monitor*.

FREDA PALTIEL, MPH, is a policy advisor with extensive experience and many publications in the fields of health, social policy, and public administration. She is the Senior Advisor, Status of Women, Health and Welfare Canada; was Canada's first Coordinator, Status of Women; serves as an advisor to the World Health Organization; and represents Canada at many intergovernmental and expert meetings. Recently, she chaired the Executive Subcommittee on Women, Health and Development of the Pan American Health Organization.

CHARLES PONÉE, MSW, MCA, a professional social worker and criminologist, has worked with the Addiction Research Foundation, in several capacities, for 23 years. Based on extensive management and labor consultation with more than 200 Canadian organizations, his current work is directed at developing innovative models for corporate health planning that may lead to worksite health promotion initiatives that would benefit all employees.

DIANE PONÉE, MSW, a professional social worker, is a program consultant with Health and Welfare Canada, Family Violence Prevention Division. For 25 years she has worked with a broad range of family and children's services related to the health needs of children and, in recent years, has given leadership on Canadian social policy related to the abuse of children. This work has involved extensive contact with colleagues in Canada and abroad.

IRVING ROOTMAN, PHD, has during the past 20 years directed several major national surveys on the health of Canadians. He was also seconded to work with the World Health Organization for several years. He is currently the Director of the Program Resources Division, Health Promotion Directorate, Health and Welfare Canada.

LINDA WILCOTT has given leadership to the Canadian Labour Congress's Employee Recovery and Union Counsellor Programs. A proponent of appropriate workplace health programs for Canadian workers, she has recently been appointed to the board of the newly established Canadian Centre on Substance Abuse.

GLENN WOLFSON, MSW, past Executive Director of the Canadian Addictions Foundation, directs one of the first Employee Assistance Programs established in a large regional government. Attuned to the unfolding of women's health issues at the workplace, he initiated a wife assault awareness program for all employees in his organization. This program has been a model for other organizations.

FOREWORD

It is inevitable that historians will see the 1980s as the decade in which health promotion emerged as "the new health agenda." And the Second International Conference on Health Promotion—held in Adelaide, Australia, in 1988—gave priority status within this field to women's health.

For several years now women have also been given special attention in various programs of the Addiction Research Foundation (ARF)—particularly research, education, and treatment services development. Thus it should not be surprising that women's health has received special attention as the Foundation has embraced the concept of health promotion and integrated that concept into workplace health programs.

Although ARF's major focus is chemical dependency, our perspective is broad. We recognize that chemical dependency does not exist in isolation, but is interactive with economic, social, and cultural contexts. Accordingly, although this book emerges from an addiction perspective, it attempts to address a broad range of women's wellness concerns in the workplace, and to explore factors and dynamics that may contribute to, or perpetuate, such problems.

The many highly regarded professionals who have contributed their expertise and energy to make this book a reality come from many disciplines and both the private and public sectors, thus reflecting the broad range of working relationships of ARF's Community Services staff. Together they have allowed the editors to present, in this one publication, a wide spectrum of women's health-related issues: from the international perspective to the local; from changing patterns of family and workplace to union efforts on behalf of women's personal health matters to the broader constituency of health professionals. As a reference text it is a logical extension of ARF's work in Employee Assistance programming.

It represents a milestone in the health promotion literature, consolidating much current information, while introducing the reader to a fresh spectrum of facts, opinions, observations, impressions, and expe-

rience. And throughout, it keeps an eye on the critical issue of what might be done in the workplace to promote the health of all workers, though particularly that of women, and how such leadership can be given. Thus while it represents a contribution in its own right, it is my hope that it will inspire others—researcher and practitioner alike—to focus their attention and their efforts in this important area as we move into the 1990s.

Joan Marshman,
Toronto
August 1989

PREFACE

As reflected in this volume, we live in a rapidly changing world. At the North American worksite, there has been no greater change than the rapid increase in the number of women employees, the expansion in their roles and responsibilities, and the tremendous impact these developments have had on the health and well-being of the female worker and her life and relationships outside the workplace. There is something very exciting and positive happening with women at the workplace; however, this "wind of change" brings with it some negative implications as well. Hopefully, these too will be adequately highlighted.

As its editors, we hope that this book—the culmination of a two-year developmental process—provides the reader with a true sense of "where women workers are" as we, as a society, rapidly move into the 1990s..

The book's stated purpose is the infusion of contemporary information, ideas, concerns, and experiences regarding the health of women workers into the contemporary worksite. It is an effort to ensure that worksite EAP personnel, health care providers, union officials, and managers optimize their efforts towards promoting the health of all workers—especially women workers who have unique needs—and to ensure that special efforts are made to assist women workers, who may be at risk in particular ways. Health promotion initiatives, early problem intervention methods, and Employee Assistance Programs all contribute in their own ways to the desirous concept of comprehensive corporate health programming being undertaken at each and every workplace.

A fundamental notion underlying the concept of this book is that the progressive contemporary organization, as an employer, has both a moral and an economic responsibility to optimize the health opportunities for all its employees and their dependants, as well as its retirees.

This book has been designed, in large measure, as a reference for workplace leaders. It is hoped that, as such, it will provide the reader with an enlightened perspective on how women's health and general sense of well-being are shaped in large measure by the context and conditions within which they live and the nature of their employment—

work conditions, organization of work, control over work (or lack of it), level of work skills, and impact of home responsibilities on work performance and vice versa. The editors and contributors hope that this objective has been achieved.

Herein, the gauntlet is thrown down to those numerous workplace EA programmers, in particular, to challenge them to ensure that their programs evolve along current "best advice" guidelines and that they make every effort to involve women workers at all levels in their organization, in the planning, implementation, and service aspects of their mandate—and further, that they support collateral workplace health programming that ensures employee health—women's in particular. Finally, EA programmers must look to creativity and innovation in order to build upon those currently accepted EAP-related activities in order to move thinking and action closer to the ideal—healthy workers in a healthy workplace. The challenge is major; however, with will and determination success will be realized. Remember, EA programmers are a part of the most major and significant humanistic development at the worksite within recent memory. Its impact to date has been both positive and impressive—for both the employee and the worksite. Its influence on organizational development should not be discounted. Employees—and women workers in particular—have everything to gain.

The Addiction Research Foundation of Ontario is to be acknowledged for its endorsation and support of this book and the ideas espoused therein. We are proud to say that many of the ideas that are promoted in this book are reflected in the ARF's work with its numerous organizational clients.

We hope that other "like-minded" worksite partners will build upon the information, ideas, observations, experiences, and beliefs that have been presented in this book for women, work, and wellness.

The Editors

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The preparation, publication, and distribution of a book such as this requires the advice, support, guidance, and physical assistance, and the good will of many people over an extended period of time.

In recognition of this fact we take this opportunity to acknowledge those individuals who have been instrumental in the delivery of this final product—of which we can all be extremely proud:

- Special appreciation is extended to Judith Groeneveld, Research Associate, Occupational Research, Social and Biological Studies Division, Addiction Resarch Foundation, for her generous counsel, assistance, and work during the development phase of the book. Without her involvement, it is unlikely that this book would have been realized.
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Finally, a book such as this could never be realized without creative authors who have the knowledge, experience, understanding, sensitivity, commitment, and determination to ensure the successful realization of the concept. To these authors—our colleagues—who gave of their work voluntarily, we are truly in debt.

OVERVIEW

SHAPING THE FUTURE FOR WOMEN: An International Perspective

FREDA L. PALTIEL

> Occupational health and safety should be enhanced by the public and private sectors. Concern with the occupational health risks should cover female as well as male workers and focus among other things on risks endangering their reproductive capabilities and unborn children. Efforts should equally be directed at the health of pregnant and lactating women, the health impact of new technologies and the harmonization of work and family responsibilities. (Nairobi Forward-Looking Strategies, Paragraph 162)

The Nairobi Conference (1985), which was the crowning achievement of the International Women's Decade (IWD, 1975 - 1985), took the guesswork out of future-shaping for women. It also showed us how far we have to go. Implementing the Nairobi Forward-Looking Strategies (FLS) for women has necessitated re-examining assumptions, exploding gender myths masquerading as science or human nature, and allocating resources to research and re-evaluation of the social histories of women and men.

The themes of the IWD were Equality, Development, and Peace, and the subthemes were Health, Employment, and Education. On the eve of the Nairobi Conference, Filomena Steady of Sierra Leone noted the gradual shift from an emphasis on human rights in the initial stages of the IWD to one on socioeconomic development, as a result of world

economic conditions and an awareness and emergence of women as "critical economic actors." During the IWD, the women's movement, aided by communications technology, eroded the false dichotomy between developed and developing countries, revealing, despite different conditions, the interrelated themes in the lives of women throughout the world, as well as the specific needs, risks, and tasks of women in particularly vulnerable situations.

Today, the formerly separate spheres of inquiry—the workplace, the economy, the political sphere, and the home and family—have begun to converge. Moreover, policymakers are taking a new interest in demography as they seek to understand the dropping birthrate, the increased divorce rate, and the aging population. Women's interests have moved out of the private domain onto the public agenda, nationally and internationally.

WOMEN'S WORK—WOMEN'S WORTH

International Labor Organization (ILO) statistics on economically active populations show that women comprise 10% to 30% of workers in developing countries and 40% to 50% of workers in the advanced industrialized states. These official statistics conceal rather than reveal the extent of women's work.

Under-assessment of the economic activity of women, particularly in developing societies, includes the under- or non-reporting of seasonal or intermittent work and the exclusion of domestic production and service activities, unpaid family work in enterprises registered in the husband's name, or service and trade activities in the informal or underground economy. Definitions of unemployment also exclude discouraged workers (Johnston, 1985).

In developing countries, rural women whose work is unenumerated and unremunerated, and classified as non-productive or informal, play major roles as farm workers, laborers, heads of farm households, marketers of agricultural produce, and processors of crops. Rural women who drift to urban slums scavenge, serve, or hawk or perform menial, monotonous, and unrewarding tasks to support themselves and their dependants.

African and Caribbean mothers plant, harvest, carry water, gather wood, market produce and crafts, and perform other onerous tasks, concurrently caring for large numbers of children of various ages. In rural Africa, Food and Agriculture Organization (FAO) data show

that fathers provide 5% and mothers provide 95% of the time devoted to feeding and caring for the family.

In Asia, the ILO has noted that young, unmarried women constitute 80% or more of Export Processing Zones (EPZ) employment. (EPZs are offshore operators set up by multinational corporations mainly in developing countries for semi- or fully processing goods for export.) Such young women, working in garment and electronic component assembly, are often redundant by age 25 and, with few marketable skills to help them to find alternative employment, may drift into prostitution.

In Western industrial societies, women remain occupationally segregated in service, sales, and clerical occupations.

Roos (1983) examined differences in labor force behavior, occupational distribution, and attainment of ever-married and never-married women in 12 industrial societies. With two exceptions (Israel and Sweden) never-married women are more likely to be working in professional and technical jobs, whereas ever-married women are more likely to be in agricultural occupations (where agriculture represents a significant sector) and in clerical and service occupations.

Earlier studies of occupational prestige, status, and social mobility ignored women on the premise that their status was derived. The most recent study by Blishen (1987) on a 1981 socioeconomic index for occupations in Canada includes scores for 514 census occupations. He looked at female concentration, pooled median income, education, and socioeconomic status (SES). Male/female wage differentials have generally been explained by human capital theory, family responsibility, work commitment, or interruptions. The income spread between female- and male-dominated occupations in the Blishen study lends ample support to the more plausible systemic discrimination (sexism) explanation. Some examples of median incomes are: fish canners, 63% female, $3,961; milk processors, 10% female, $14,539; book binders, 71% female, $9,577; firefighters, 1% female, $24,061; welfare and community workers, 69% female, $14,648; construction managers, 2% female, $25,760.

A U.S. study predicted that by the year 2000, women's salaries as a percentage of men's, hovering at around 60% for many years, would rise to 75% (Smith & Ward, 1984). However, this attainment, without heroic efforts, is questionable given the current positions of women and men on the American occupational ladder where women constitute 80%

of administrative support workers and only 7% of all jobs held by women are in high levels (Office of Technological Assessment—OTA, 1985).

In addition to the segregated labor force by sector and occupation, there is the question of primary and secondary, core and peripheral, regulated and unregulated labor force. A disproportionate number of women have been assigned to the second of each of these pairings. Women in North America, like their Third World sisters, in recent years when secure well-paid jobs have been difficult to obtain, have become very resourceful. As barriers to access to credit were reduced, unprecedented numbers of women have become small-scale entrepreneurs marketing skills and wares. Other women have taken on two or three jobs to earn a living wage for themselves and dependants, but not without stress due to the part-time or precarious nature of their "attachment" and their losing out on work-related pensions and other benefits.

Growth models may widen differences between rich and poor both between and within countries, in income and in technological and skill acquisition; may substitute capital for labor, causing unemployment and deskilling; and may engender conspicuous consumption for elites and shortage of goods for the poor. Researchers during the IWD began to document the ways in which economic growth and modernization have been detrimental to the female labor force (Paltiel, 1988). In Brazil, for example, women's average wages in comparison to men's dropped from 61.1% in 1970 to 48.6% in 1976. A Brazilian study in 1970 showed that more women than men in the textile industry worked 49 hours per week. Clearly the goal is balanced growth with social equity (Saffioti, 1983). A 1984 study (Smith & Ward, 1984) of male/female wage disparities in Asia noted that disparities are more pronounced in the more advanced economies, illustrating once more that economic "progress" without political commitment to equity can contribute to the feminization of poverty.

International and national policies affecting remuneration of women and employment equity have been slow to have any impact. Specifically, the ILO Convention on Equal Remuneration (No. 100, 1951, which formulated the principle of equal remuneration for work of equal value), despite ratification by over 100 countries, has been slow in penetrating the policies and practices of most countries, and gains are not always secured in perpetuity. For instance, employment equity legislation has existed in the U.S. since 1963 and in the U.K. since 1970. In the

latter, 1984 regulations placed the onus on the complainant to demonstrate that the work was substantially similar.

In 1975, the European Economic Community launched a series of measures to achieve equality between men and women in the workplace and in society. In 1980, Organization for Economic Co-operation and Development labor ministers adopted a declaration that called for integrated policies to eliminate segregation in employment, reduce differentials in average earnings, implement equal pay for work of equal value, encourage more flexible working arrangements, and endeavor to ensure that provision of taxation, social-security, and child-support systems does not bias the decision of men and women on how they allocate their time between paid employment and other activities.

The United Nations Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), ratified by Canada in 1981, calls for states to ensure equal pay for work of equal value. The Canadian Human Rights Act and the Acts of several provincial jurisdictions comply with this provision, which compares similar jobs for skill, effort, responsibility, and working conditions in the same establishment. Federal employees in female-dominated occupations (e.g., library science, home economics, and hospital services) have received retroactive and continuing pay adjustments, more truly reflecting the value of the job rather than the gender of its holder.

It was a painful truth in the past that trade unions were no more egalitarian in their outlooks and practices than other social institutions. Today, women constitute 30% of the International Confederation of Free Trade Unions' (ICFTU) 80-million membership, and union agendas are changing, but few women occupy senior elected or appointed positions.

In Western countries, rates of union female membership range from a high of 80% in Sweden, where most women work part-time, to rates in the 20% to 40% range in countries such as the U.S., Canada, and West Germany. In the U.K., the National Union of Public Employees found that lack of interest was not the reason for underrepresentation of women union members but that reorganized union activities to fit women's needs (e.g., meetings during worktime, childcare facilities, and women's advisory committees) were needed.

In Canada, public service unions have been actively promoting issues such as adequate maternity benefits; and the largest umbrella organization, the Canadian Labour Congress, the first major national

workers' organization headed by a woman, has been pursuing the parental concerns of its members and has entered into coalitions with advocacy organizations on behalf of improved childcare. In the U.S., even though overall rates of unionization have dropped dramatically, women's unionized rates have increased 25% over the last 10 years.

At the ICFTU's World Congress of 1983, affiliated organizations were asked to ensure strict adherence to the principle of equality of opportunity and treatment for men and women workers, without prejudice to positive action programs and maintenance of the health, social, and family services that are the foundation for this equality.

WOMEN'S WORK—WOMEN'S HEALTH

The principle of *women in development* is that women, equally with men, should be agents, architects, and beneficiaries of the development process. The concept of *women's health and development* denotes the complex interrelationships between the health of women and their social, political, cultural, and economic situations. Australian, American, and Canadian sources confirm that *women and health* will emerge as a foremost public policy issue in the 1990s (Women's Health in a Changing Society, Adelaide, Australia, 1986; National Conference on Women's Health, Bethesda, Maryland, 1987; National Symposium on Changing Patterns of Health and Disease in Canadian Women, Ottawa, 1988).

Women are not only the major providers of health care everywhere but also the major brokers, guardians, unpaid caregivers, and major users because of their reproductive functions, longevity, and experience of chronic diseases. Although Canadian women live over 7 years longer than men, their disability-free life expectancy is only 3.6 years longer, and they can expect to have some form of disability for about 15.5 years compared to 11.6 years for men (Rootman, 1988). Chronic, disabling diseases are often insidious in onset, characterized by remissions and exacerbations, difficult to diagnose, lacking cure, occasioning multiple medical referrals and continuous medical supervision. These factors—rather than women's greater expressiveness about illness, their alleged proclivity to seek medical care, or Parsonian retreat into "the sick role"—explain women's extensive reliance upon the health care system.

Health authorities in Canada, as elsewhere, are being faced with difficult challenges for health care provision: for example, shortages of

nurses (95% female), of occupational therapists (87% female), of physiotherapists (84% female), and of speech therapists (87% female) and the exhaustion and/or unavailability of full-time female "informal" caregivers (Buck, 1988). Critical decisions are demanded about midwifery, AIDS, abortion, adolescent pregnancy, and the ethics and efficacy of new reproductive technologies, together with appropriate care for aging populations. Additional challenges are prevention, care, and management of sex-specific and sex-dominant diseases (e.g., breast cancer, cervical cancer, osteoporosis, Alzheimer's, anorexia, and bulimia). Formerly each of these reached policy-makers and clinicians as discrete problems. What has changed is women's consciousness.

Throughout the world, health has emerged as a foremost concern of women, a concern that will demand coherent, effective responses requiring the much fuller participation of women in policy, program, and service development and delivery. The predominance of women in the health sector and their virtual absence in decision-making affecting their health and that of their families and communities is a situation undergoing increasing scrutiny and bound to change in the coming decade. Institutional targets for greater parity in senior positions were set in relation to what was considered realistic in comparison with the low representation rates observed pre-Nairobi. A 1988 Australian policy paper on women's health calls for that government to "maintain and develop mechanisms which increase women's participation and representation in all decision making processes within health systems." Canadian participants in the National Symposium on Changing Patterns of Health and Disease in Canadian Women called for political action to place women in policy-making arenas; their specification that 50% of all government senior management and executive manager positions should be filled by women by 1990(!) reflected the mood of impatience.

The Eighth Commonwealth Health Ministers' Meeting in the Bahamas in 1986, which confirmed female predominance as health care providers and male predominance in the professional and the higher-paid categories, called upon members to improve training for better communication with community members, particularly women, with regard to self-reliance and the care of their own health.

The 1988 World Health Promotion Conference in Adelaide, Australia, identified supporting the health of women as a priority and affirmed that all women, especially those from ethnic, indigenous, and

minority groups, have the right to self-determination of their health and should be full partners in the formulation of healthy public policy to ensure its cultural relevance. It called for a national women's healthy public policy; the equal sharing of caring work; birthing practices based on women's preferences and needs; and the creation of supportive living and work environments to safeguard health from direct and indirect adverse effects of biological, chemical, and physical factors as part of a concept of sustainable development with ecological protection, echoing the Bruntland Report.

OCCUPATIONAL STRESS AND BURNOUT

Warshaw (1979) has termed stress the most noxious substance in the workplace. Selye (1976) defined stress as the non-specific response of the body to demands, pleasant or unpleasant, with arousal depending on the intensity of the demand for adjustment or adaptation. Until recently virtually all stress studies were done on males.

In 1986, out of the 5.6 million Canadian women in the labor force, 3.2 million were in clerical, sales, and service occupations. We are beginning to discern the health implications of this occupational concentration.

Occupational stress has been noted in connection with the high-speed assembly line, machine work, or rapid-paced work. Coercion, demands for sustained attention, monotony and repetition, and overload and underload are additional work factors associated with stress, as are job insecurity, a poor quality of supervision, and lack of opportunity for social interaction. Frankenhaeuser (1980) found that conditions characterized by uncertainty, unpredictability, and lack of control usually produce a rise in adrenal output; since most women work in subordinate positions, these three work conditions affect large numbers of them.

The rapid introduction of video display terminals (VDTs) in the workplace, most often where female clerical workers are concentrated, has given rise to stress studies in this new group of machine-yoked, machine-paced, pink-collar workers. Musculoskeletal stress, attributed to workplace design problems, has affected VDT operators who sit in stationary positions for long periods every workday. Studies have found that lower-level workers (i.e., clerks with high work demands and low control and content) were more likely than managers or professionals to experience stress-related health effects. Stellman, Klitzman, and

Gordon (1987) found that typists and clerical workers in supervisory positions reported fewer stressors and greater job satisfaction than workers without supervisory tasks, but the differences between these groups disappeared when they were engaged in all-day VDT work.

Among VDT workers, the potential human health effects that have received attention are radiation, ergonomic effects, stress, skin disorders, and eyesight problems (blurred vision, eyestrain, and headaches—more pronounced in persons aged over 40). Musculoskeletal complaints are more common among VDT workers than other office workers; repetitive tasks, immobility, machine pacing, and poor design of desk, chair, equipment, and lighting are factors. Periodic rest periods and task differentiation; better design of the worksite for flexibility, reliability, comfort, lighting, and ventilation; and control over work organization and conditions—all favor improved health for VDT users (Paltiel, 1988).

A more baffling aspect of women's exposure to VDTs has been the reported occurrence of about a dozen clusters of various adverse events in pregnant workers at various sites in the U.S., Canada, Japan, and the Nordic countries. Investigations established no causal link between radiation emissions from VDTs and reported spontaneous abortions, birth defects, cataracts, or other injuries (AMA Council on Scientific Affairs, 1987). A recent Swedish case control study reopened the question with its finding of a higher rate of spontaneous abortion and possibly congenital malformation in a group with the highest probability for video screen exposure; in a group with medium exposure, a higher than expected rate of low birth weight was noted (Ericson & Kallen, 1986).

Goldhaber, Polen, and Hiatt (1988), in a case control study of pregnancy outcome of 1,583 pregnant women in three Kaiser Permanente Clinics, found a significantly elevated risk of miscarriage for women reporting more than 20 hours per week of VDT work in the first trimester of pregnancy compared with working women not using VDTs. The authors conclude that the hazards of VDT remain a possibility, but may be due to unmeasured factors, ergonomic or stress. They call for large, carefully conducted epidemiological studies to establish whether or not reproductive health problems exist. In the meantime, the right to refuse VDT work by pregnant women is respected in a number of jurisdictions.

Burnout may be the modern term for intellectual alienation. Maslach and Jackson, who defined it as a syndrome of exhaustion and cynicism occurring frequently among individuals who do "people work," found that females scored higher than males for emotional exhaustion in frequency and intensity (Paltiel, 1988).

The bureaucratization of societies has brought about a formalization in the delivery of services and ideological conflict about who should be responsible for their payment and provision. A concomitant "laissez-faire" attitude has permitted the belief that women could expand their repertoire of duties as workers and citizens and at the same time maintain all their family responsibilities.

It is not surprising that women in the nurturant occupations and professions are highly vulnerable workers. Studies indicate that burnout in health and social service professions is a major factor in low worker morale, absenteeism, high job turnover, and other indices of job stress. Institutional caregivers are particularly vulnerable to burnout and what I term nurture-stress, as they are often charged with the heavy care of persons who have exhausted the capacities of family members. Humanizing institutional care for those who can no longer be cared for at home or cannot manage independently requires careful attention to the needs, risks, and tasks of both care receivers and givers. Indeed, studies have shown that women physicians with high commitment to work or with high commitment to family cope very well. But those who have high commitment to both work and family experience extreme stress (role strain). EAP workers may also be at risk if the service is a form of tokenism, without adequate investment of resources and structural supports for the program.

WHO CARES?

North Americans have always been intrigued by Nordic models of egalitarianism. However, Schonnesson (1987) writes of the "Her, His and Their Marriage" of Swedish married couples. She found, generally speaking, that wives (regardless of family life stage) were more dissatisfied with their family life than their husbands and that the wives, who most often work part-time, take responsibility for the household. In addition to the above-cited international instruments that say this shouldn't be so, the 1981 ILO resolution and convention (No. 156) concerning equal opportunities and equal treatment for men and women provides clear policy directives:

> With a view to creating effective equality of opportunity and treatment for men and women workers, each member shall make it an aim of national policy to enable persons with family responsibilities who are engaged or wish to engage in employment to exercise their right to do so without being subject to discrimination and, to the extent possible, without conflict between their employment and family responsibilities.

We have been slow to acknowledge that exclusive care by the mother is a very recent phenomenon in human history, one that is isolating, with potential for damage to both mother and child. While women's labor force participation rates do not vary dramatically among Western industrialized countries, childcare and early childhood education receive very different treatment in public policy.

In France (and in some regions of Belgium) the *école maternelle* delivered by the education system is virtually a universal experience for the children we call preschoolers. About four-fifths of children aged 2 to 5 (and an even higher proportion of children aged 3 and over in Paris) are enrolled in the flexible neighborhood program, which is also available to school-age children before and after school.

In contrast, as the President of the Carnegie Corporation of New York has pointed out, the United States in 1986 spent $264 billion on education of children aged 6 and older compared with about $1 billion for children aged 5 and under. Yet, he noted, early childhood is one of the most crucial periods of emotional, social, and cognitive development in the life span, one characterized by developmental rapidity, major shaping influences, and vulnerability with long consequences.

In Australia, childcare is described as a major issue in encouraging women back into the health workforce, particularly senior nursing staff, of which there is a shortage. The nurses require not only adequate facilities but childcare that operates over extended hours or 24 hours to accommodate shift workers. The establishment of work-related/extended-hours childcare is a new challenge in Australia, as elsewhere.

Adequacy of coverage and flexibility are challenges to childcare systems. Canada's recently introduced Child Care Initiatives Fund (of $100 million over 7 years) seeks to address the challenges by its support of projects that encourage and evaluate innovation in services for children of shift workers and part-time workers, for Indian and Inuit children and those from other minority cultural backgrounds, for rural children, for children who require short-term, respite, or emergency care, and for school-age children.

Midlife and Older Women

The current cohort of midlife women are quite different in family life experience, opportunities, and role expectations from the baby boomers who will enter midlife at the turn of the century. They—the sandwich generation—may be caring for three generations: children, spouse, and parents. Most women who are divorced or widowed at midlife will be heads of households for considerable periods; many will never remarry (Shaw, 1983).

Some older women in middle management or senior clerical positions may have lacked an opportunity structure that recognized and rewarded their skills and loyalty. There may be friction between them and younger male or female supervisors; and indeed the conflict between experience and formal training may be misconstrued as personality problems, and improperly addressed.

Additional education and training can mitigate risks of poverty, and worksite age/sex-appropriate health promotion can improve or maintain health (McDaniel, 1988). As workers reach retirement age, retirement courses that are currently addressing the needs of married males should be shaped to address the needs of older women as well.

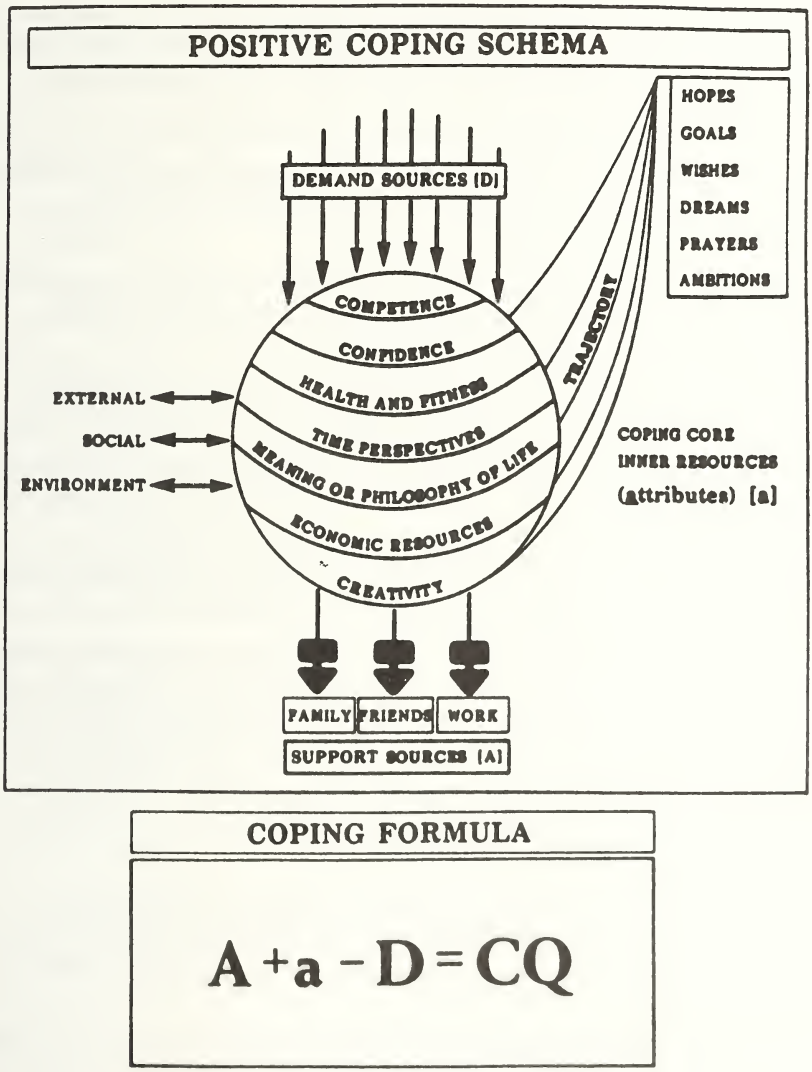
Coping and Control

Canada's commitment to health for all includes three challenges: reducing inequities, increasing prevention, and enhancing capacity to cope. For more than a decade the author has been working on a new conceptual model for policy development that involves the determination of needs, risks, and tasks of women and men throughout the life cycle. A three-anchor needs/supports proposition was developed based on work, family, and friends. While various authors are increasingly emphasizing the importance of support systems to reduce vulnerability, this author insists that the source of support is an important key to assessing and reducing vulnerability. The absence of two anchors signals high vulnerability (Paltiel, 1981).

More recently this idea has been incorporated into a positive coping schema and coping formula in which these three anchors serve as support sources, balanced against an inventory of demands and mediated both by external environmental factors and the attributes or inner resources of the individual, with all of these related to a person's aspirations (Figure 1). The formula is: Anchors (A) plus attributes (a) minus Demands (D) equals the Coping Quotient. This formula can be tested and applied within those EAPs that seek to enhance individual

coping and control, in the realization that personality is only one of the factors to be considered and that even personal attributes can be acquired only when discriminatory obstacles to their attainment are removed, positive action promotes their acquisition, and aspirations are nourished.

FIGURE 1



Source: F.L. Paltiel. (1987). Is poverty a mental health hazard? *Women and Health, 12* (3/4)

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CANADIAN WORKING WOMEN: A Profile

VIRGINIA CARVER

HISTORICAL OVERVIEW

The year 1980 marked the first time in Canadian history that the majority of Canadian women (50.3%) were officially in the labor force* (Labour Canada, 1983). This milestone represents part of a trend that has radically changed the make-up of the Canadian workforce, and made work outside the home the norm for the majority of Canadian women regardless of age, marital status, or family responsibilities.

As Cameron (1981) points out, women have always worked. Before the industrial revolution, the unit of labor was the family—husband, wife, and children. With the advent of the industrial revolution, workers moved from the land into the factories. Though women and children still worked, the skilled jobs, and hence better wages, were given to men. As wages rose, it became increasingly possible for men to be the sole financial support of their families. Particularly in the middle and upper classes, it became the norm for married women to expect to be financially supported by their husbands, and for women to be delegated to the tasks of childbearing, childrearing, and household management (Cameron, 1981).

* The labor force is that part of the civilian non-institutional population 15 years of age and over who are either employed or unemployed (looking for work). Labor force participation rate is the percentage of the population or some part thereof (i.e., all women in Canada 15 years and over) who were either employed or unemployed.

The two world wars, most especially the Second World War, saw many women returning to the labor force to free men for the armed forces. Particularly in front-line countries such as Russia and Great Britain, the conscription of women and the drafting of most able-bodied men into the armed forces meant that women took on jobs for which they had previously never been considered fit or able. Women manufactured armaments, did heavy labor on the land, worked on anti-aircraft batteries, and even flew combat aircraft.

However, at the end of the war, many women returned to their traditional role as homemakers. In Canada, with initiatives such as the training of household workers, payment of family allowances to women and the federal civil service restriction on the employment of married women, female labor force participation rates dropped from their 1945 high of 33.2% to percentages in the mid-20s (Armstrong & Armstrong, 1978; Statistics Canada, 1988a).

TRENDS, TRENDS, TRENDS

As can be seen from Figure 1, the movement of women back into the labor force started in the decade 1961 to 1971, and many of the women who were part of this trend were born during or directly after the Second World War.

A number of factors appear to account for this relatively sudden change in the make-up of the Canadian labor force. These include smaller families, due to better family planning methods and the likelihood that most children born will survive to adulthood; a trend for many women to postpone childbirth to the late twenties or early thirties, allowing them to establish themselves in a career before starting a family; smaller households with often only the husband and wife available as potential breadwinners, and the perceived need for two incomes to offset rising costs and inflation; better educational opportunities for women and the lifting of restrictions on the employment of women as well as changing attitudes towards women working outside the home; government legislation covering such areas as employment equity, human rights, and restrictive hiring practices; and the creation of jobs in the service sector and in part-time work, both of which provide opportunities for women (Armstrong & Armstrong, 1978; Boulet & Lavallée, 1984; Cameron, 1981; Health & Welfare Canada, 1987).

In 1951 just over one worker in five (22.0%) was female (Statistics Canada, 1988a); by 1986, this figure had nearly doubled to 43.0% or

decade and a half. For this group the rate has risen from 39.5% in 1970 to 73.7% in 1987 (Labour Canada, 1983; Statistics Canada, 1988b).

Marriage

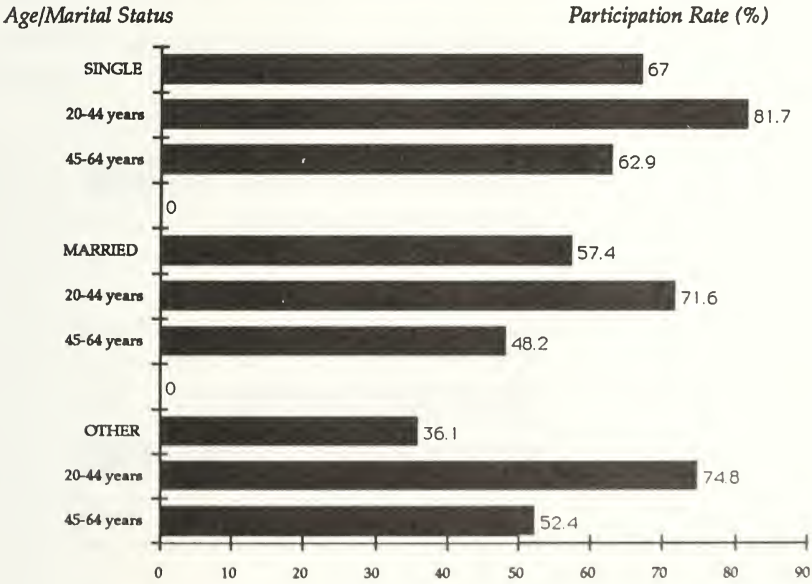
Being married, and having children, also influence a woman's participation in the labor force—but to a far lesser extent than in earlier decades.

Figure 3 shows participation by marital status and age. Though single women, particularly in the age group 20 to 44 years, have the highest participation rate, the rates for both married and previously married women in the same age group are also high.

In addition, the largest increase in labor force participation rates has occurred for married women. Between 1975 and 1983, their rate of participation in the labor force increased almost eleven percentage points. In contrast, the rate for single women increased by just under two percentage points (Statistics Canada, 1985).

FIGURE 3

FEMALE LABOR FORCE PARTICIPATION RATES BY MARITAL STATUS AND AGE, CANADA, 1987



• Divorced, separated, widowed

Source: Statistics Canada (1988b).

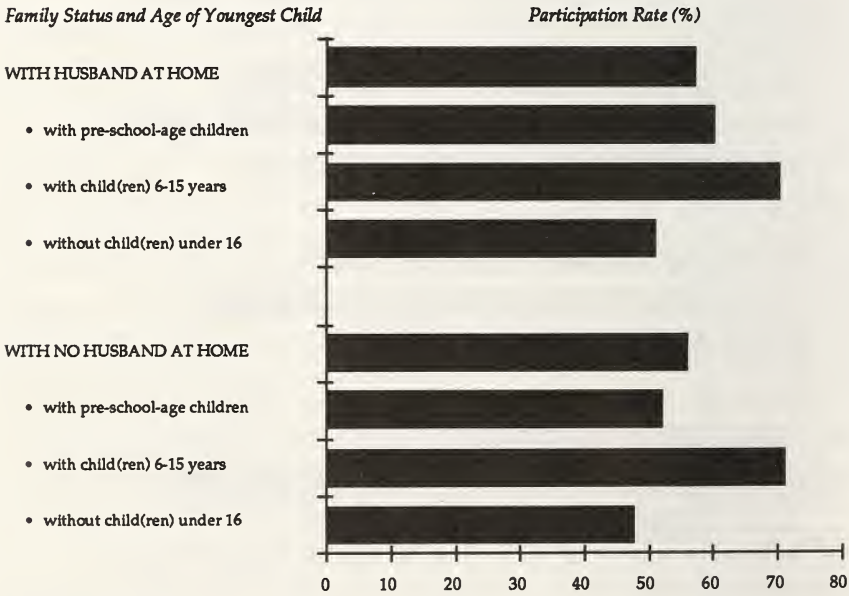
Family Status

What difference do children make to women's participation in the labor force? In previous generations marriage, and more particularly motherhood, were not considered compatible with work outside the home. This is not as true now. Figure 4 shows that over 50% of women with preschool children are in the labor force, regardless of whether or not they are in a two-parent household. This rate rises to over 70% for women with school-age children (Statistics Canada, 1988b).

A profile of women's labor market activity developed by Statistics Canada and Employment and Immigration Canada (1988) shows that in 1986, 72% of married women of working age (16-69 years), and with children under 16 years of age, were in the labor force at some time during that year; 41% of married women with children under 16 years of age were employed for a full year.

FIGURE 4

FEMALE LABOR FORCE PARTICIPATION RATES BY FAMILY STATUS AND AGE OF YOUNGEST CHILD, CANADA, 1987



Source: Statistics Canada (1988b).

However, even if they are employed outside the home, the primary responsibility for home and family care still falls to women (Statistics Canada, 1985). That is, women may have to contend with the often conflicting demands of work and family—school holidays, family illness, after-school care, and the daily responsibility of feeding and caring for husband and children and running the home.

EDUCATION

Women have made enormous gains in acquiring academic and professional qualifications. Women now comprise just over half the enrolment at community colleges and just over half of those receiving bachelor's and first professional degrees. The number of women receiving master's and doctoral degrees increased threefold and fourfold respectively from 1970 to 1985. Women now receive 42.0% of master's degrees and 26.4% of doctoral degrees. In contrast, the number of men receiving master's and doctoral degrees increased by only 13.3% and 18.3% respectively in the same time period (Labour Canada, 1987).

Though women still make up the majority of enrolment in the fields of education, humanities, nursing, and fine and applied arts, they have also increased their enrolment in disciplines previously considered traditionally male fields. Table 1 shows that in the 10 years from 1975 to 1985, the percentage of degrees granted to women in the fields of agriculture/biological sciences, health professions, engineering, and mathematics/physical sciences increased substantially at both the undergraduate and postgraduate levels (Labour Canada, 1987).

What are the implications of increased education for working women? Higher educational levels are clearly related to labor force participation rates. Rates for women with a university degree are more than triple those of women with eight years or less of education: 78.6% compared to 24.4% (Statistics Canada, 1988b). Though the average income of women is still considerably below that of men, women with postsecondary education or a university degree earned a higher percentage of men's income than did women with less education, as Table 2 demonstrates (Statistics Canada, 1988d). Finally, the higher a woman's education, the greater likelihood she will participate in the labor force, the longer she will stay, and the less time she will spend out of the labor force, such as for childrearing (Cameron, 1981).

TABLE 1

PERCENTAGE OF TOTAL DEGREES GRANTED TO WOMEN BY FIELD OF STUDY, CANADA, 1975, 1985

	Bachelor's		*Master's*		*Doctoral*	
Field of Study	*1975*	*1985*	*1975*	*1985*	*1975*	*1985*
Education	59.2	71.3	31.0	58.1	29.1	38.3
Fine/applied arts	60.4	64.3	50.0	56.8	28.6	41.7
Humanities	54.8	61.1	45.7	56.2	23.6	41.7
Social sciences	35.3	49.9	24.1	38.7	8.2	32.8
Agriculture/biological sciences	46.2	56.0	27.7	38.5	17.4	24.7
Engineering	2.7	11.6	3.8	10.5	4.0	6.5
Health professions	52.6	65.6	51.2	61.0	20.5	26.1
Medicine	24.3	40.1	33.3	—	—	—
Nursing	97.0	96.7	94.5	96.6	—	—
Mathematics/physical sciences	21.8	29.3	13.0	21.8	7.2	17.6
Total	44.8	51.9	28.2	42.0	16.1	26.4

Source: Statistics Canada, Education, Culture & Tourism Division, found in Labour Canada (1987), Tables III-5, III-7, III-9, III-11.

TABLE 2

AVERAGE INCOME BY EDUCATION AND SEX, CANADA, 1987

Education	*Women*	*Men*	*Women's Income as a Percentage of Men's Income*
0-8 years	$9,653	$18,548	52.0
Some high school and no postsecondary	12,250	22,483	54.5
Some postsecondary	13,346	22,210	60.1
Postsecondary certificate or diploma	17,219	27,855	61.8
University degree	24,987	40,897	61.1

Source: Statistics Canada (1988d).

OCCUPATION AND OCCUPATIONAL SEGREGATION

In spite of the gains made by women in education and in sheer numbers in the labor force, the distribution of women in the various industries and occupational categories shows that there are still "men's jobs" and "women's jobs." To quote Armstrong and Armstrong (1983): "Most women now work for pay, but most still do women's work."

In 1987, 57.9% of all women in the labor force were in clerical, sales, or service occupations. As Table 3 shows, women form the majority of workers in only five of 21 occupational categories (excluding "unclassified"). By and large, these occupations can be seen as reflecting the roles and activities that women have always undertaken—caring for, nurturing, and serving other people.

Another way of looking at women's work is to examine the industrial sectors in which they are employed. These can be divided into

TABLE 3

LABOR FORCE BY OCCUPATION AND SEX, CANADA, 1987

Occupation	*Women* (000)	*Men* (000)	*Total* (000)	*Women as a Percentage of the Total Labor Force in Each Occupational Category* %
Managerial and administrative	530	975	1,505	35.2
Natural sciences, engineering, and mathematics	83	358	441	18.8
Social sciences	119	96	215	55.3
Religion	7	25	32	21.9
Teaching	338	210	549	61.6
Medicine and health	498	124	621	80.2
Artistic and recreational occupations	107	135	242	44.2
Clerical	1,715	435	2,151	79.7
Sales	559	658	1,218	45.9
Service	1,026	761	1,787	57.4
Agriculture	132	398	529	25.0
Fishing, hunting, and trapping	4	39	43	9.3
Forestry and logging	4	71	75	5.3
Mining and quarrying	—	63	64	—
Processing	93	309	402	23.1
Machining	19	265	284	6.7
Product fabricating, assembling	240	820	1,060	22.6
Construction trades	16	790	806	2.0
Transport equipment operation	36	468	505	7.1
Materials handling	70	267	337	20.8
Other crafts and equipment operating	37	122	159	23.3
Unclassified	59	37	96	61.5
All occupational categories	5,694	7,427	13,121	43.3

Source: Statistics Canada (1988b).

goods-producing and service industries. Table 4 shows that women are the majority of the labor force in the service industries.

As one report notes, jobs in the service industries are "often part-time, low paying, and offer few fringe benefits and little potential for promotion or career advancement" (Statistics Canada, 1985, p. 43).

However, though slow, there are changes in the occupational profiles of women. The percentage of women in managerial and administrative occupations has almost doubled—from 4.9% in 1980 to 9.3% in 1987 (Labour Canada, 1983; Statistics Canada, 1988b). However, many of these may be in lower-level supervisory roles and concentrated in traditionally female-dominated work sectors such as service and health (Armstrong & Armstrong, 1983). Some occupational categories where women predominate, such as clerical and medicine/health, in fact show either a very small increase or a decline in numbers of women workers between the census years of 1981 and 1986 (Statistics Canada, 1988c).

Similarly, Boulet and Lavallée (1984) have documented the increasing numbers of women entering the more highly paid professions such as management, medicine, law, and university teaching. They note that the number of women in the 20 highest-paid professions quadrupled in the 10-year period between 1971 and 1981. Also the number of women employed in male-dominated professions increased 174.1% between 1974 and 1981 (Marshall, 1987). Data from the 1986 census also found increasing numbers of women entering male-dominated occupations, ranging from industrial engineer and physician/surgeon to bus driver and motor vehicle mechanic (Statistics Canada, 1988c). Such women were likely to have more education, a higher employment rate, and larger incomes in comparison with other women professionals (Marshall, 1987). Unfortunately, there is also what some may interpret as a "price to pay." Women in male-dominated professions were more likely never to have married, or not to be living with a spouse, and to have none or fewer children than other women professionals or men in male-dominated professions (Marshall, 1987).

Also, Boulet and Lavallée (1984) note that the number of women entering the lowest-paid occupations doubled between 1971 and 1981, while numbers for men showed only a slight increase.

TABLE 4

PERCENTAGE DISTRIBUTION OF WOMEN, AND WOMEN AS PERCENTAGE OF TOTAL LABOR FORCE, IN VARIOUS INDUSTRIAL CATEGORIES, CANADA, 1987

Industry	*Percentage Distribution*	*Women as a Percentage in Each Industrial Category*
Goods-producing		
Agriculture	2.6	29.5
Other primary industries	.7	12.5
Manufacturing	11.4	29.1
Construction	1.3	9.3
Service industries		
Transportation, communications, other utilities	4.1	24.2
Trade	17.9	44.5
Finance, insurance, real estate	7.7	60.4
Service	47.0	62.4
Public administration	6.2	40.0
Unclassified	1.0	61.5

Source: Statistics Canada (1988b).

PATTERNS OF EMPLOYMENT

Just as types of jobs differ between men and women, so do patterns of employment. Women are more likely than men to work part-time. In 1987, the majority (71.8%) of those in part-time employment were women (Statistics Canada, 1988b). The percentage of employed women who worked part-time was 25.3% in 1987.

A number of factors may account for the predominance of women in part-time work. For some women, part-time work allows

them to attend to family responsibilities that are more likely to devolve upon women than men. Only 0.8% of males indicated family responsibilities as a reason for part-time employment versus 12% of females (Statistics Canada, 1988b).

In addition, there has been considerable growth in part-time employment opportunities for women, particularly in the service sector. Between 1980 and 1985, overall part-time employment for women grew 24.9%, compared to 9.4% for full-time employment. In the service sector the figures were 27.3% for part-time employment and 11.8% for full-time employment (Labour Canada, 1987).

Though many women may choose to work part-time, many also would like to work more hours. In 1986, 28% of women working part-time would have liked to work more hours each month and 17% would have liked to work full-time (Statistics Canada and Employment and Immigration Canada, 1988).

In terms of duration of employment, the average duration of employment for women employed full-time is now 5.4 years, as compared to 7.3 years for men. Women employed part-time exceed men in duration of employment: 3.3 years versus 2.0 years (Statistics Canada and Employment and Immigration Canada, 1988).

Boulet and Lavallée's (1984) analysis of trends in duration of women's employment shows that the percentage of women holding their jobs for 10 or more years increased from 31% in 1976 to 35% in 1981. The comparable figures for men are 52% and 55%. Some 16% of women versus 37% of men have been with the same employer for 20 or more years.

Unemployment rates for men and women are generally similar, though the overall rate is slightly higher for women (10.7% versus 10.3%). For both sexes, unemployment rates are highest in the youngest age group, those under 25 years of age (Labour Canada, 1987).

EARNINGS

Whether employed full-time or part-time, women's average earned income for a full year is 60.9% of men's (Statistics Canada, 1987). Women working full-time are twice as likely as men to be in the lowest earned-income bracket, under $10,000: 16.1% of full-time women workers fall in this salary range (Statistics Canada, 1987). In contrast, men whether working full- or part-time are at least twice as likely as women

to earn over $25,000. Table 5 shows this percentage distribution of workers by earnings group for men and women.

TABLE 5

PERCENTAGE DISTRIBUTION OF EARNERS BY EARNINGS GROUP, SEX, AND FULL-TIME AND PART-TIME STATUS, CANADA, 1986

	Women		*Men*	
Earnings Group	*Full-time*	*Part-time*	*Full-time*	*Part-time*
Under $10,000	16.1	74.2	8.7	63.8
$10,000 - $14,999	18.5	12.3	8.1	14.0
$15,000 - $19,999	20.9	6.8	10.6	8.3
$20,000 - $24,999	18.1	3.1	13.2	5.0
$25,000 and over	26.3	3.5	59.3	9.0

Source: Statistics Canada (1987).

As noted in Table 6, women earn less than men in every major occupational category.

The differential also exists regardless of level of education, as was shown earlier in Table 2. An analysis by Boulet and Lavallée (1984) also found that at every level of education from "secondary school or less" to "postgraduate degree," the hourly and annual earnings of men exceeded those of women, though the difference is slightly less for hourly earnings.

Though there is still a large gap between men's and women's

earnings, this gap is narrowing. Boulet and Lavallée (1984) point to increased education and unionization as two factors contributing to better earnings for women. In 1967 women working full-time for a full year earned on average 58.4% of men's earnings. By 1986 the average earnings of full-time women workers working for a full year were 66.0% of men's average earnings (Statistics Canada, 1987).

TABLE 6

WOMEN'S EARNINGS AS A PERCENTAGE OF MEN'S EARNINGS BASED ON AVERAGE EARNED INCOME OF FULL-YEAR WORKERS BY MAJOR OCCUPATION AND SEX, CANADA, 1976, 1981, 1985

	Year		
Occupation	*1976*	*1981*	*1985*
Managerial	53.1	56.4	59.8
Professional	60.3	62.5	63.7
Clerical	62.0	63.8	66.6
Sales	44.4	53.0	51.0
Service	44.8	52.7	51.3
Farming, logging, fishing, etc.	—	52.5	58.2
Processing, machining	61.7	53.9	65.3
Product fabrication	53.9	56.1	57.3
Transportation, communications, etc.	62.2	57.8	59.2

Sources: Labour Canada (1984b, 1987).

PENSIONS

There is also a gender gap in pension eligibility and pensions paid. In 1980, only 57.1% of women aged 18 to 64 years were contributors to the Canada Pension Plan or Quebec Pension Plan, as compared to 90.5% of men; and only just over a third of paid women workers were private pension plan members (Statistics Canada, 1985). Within both the goods-producing and service industries, the percentage of men covered by private pension plans exceeds the percentage of women (Labour Canada, 1986).

In terms of Canada Pension Plan benefits, based on figures for September 1988, only 48.3% of women, as compared to 81.3% of men, received benefits at the highest rate of $200 and over per month (Health and Welfare Canada, 1988).

Though the gap is narrowing in CPP/QPP and private pension plans, it may not disappear completely. Many women still work part-time, in non-unionized companies, or in companies not covered by private pension plans; the number of years in the same job or with the same employer is still lower for women; and since pension plans are a reflection of wage/salary levels, older women may continue to remain those most at risk for poverty.

UNIONIZATION

Along with the increased growth in the female labor force, there has been an increase in both the percentage of women who are unionized and the percentage of union members who are women.

In 1976, 27.4% of union members were women and 21.2% of paid women workers were unionized (Statistics Canada, 1989). By 1986, the proportions had increased such that 36.6% of union members were women and 28.4% of paid women workers were unionized (Statistics Canada, 1989).

Unionization rates for part-time workers are generally somewhat lower. A 1984 survey of union membership (Labour Canada, 1986) found the unionization rate for full-time paid women workers was 35.8% as opposed to 20.9% for part-time women workers.

Unionization in particular affects earnings. In 1986, the average weekly earnings for all unionized jobs held by women were $338, compared with $242 for non-unionized jobs held by women (Statistics Canada and Employment and Immigration Canada, 1988).

In service occupations, unionized women earned on average 81% more than non-unionized women. At the other end of the scale there was a 32% difference in the average earnings between women in unionized and in non-unionized managerial, professional, and technical jobs (Statistics Canada and Employment and Immigration Canada, 1988).

CONCLUSION

Nearly one in two Canadian workers is female and, if the rate of growth in the female labor force continues to outstrip the growth rate in the male labor force, women will soon be equally represented, at least in numbers.

This is as it should be! Women represent half the human resources and talent available. It makes sound economic and social sense that jobs should be filled by those with the most appropriate education and skills regardless of gender.

Along with changes in attitudes to women's work, and the expectation that most women will now work most of their adult life, there have been increased educational opportunities, the lifting of restrictive employment practices, and initiation of employment equity legislation at both federal and provincial levels. All these factors make the workplace increasingly "woman friendly"—a boon to all workers.

At the same time, the organization of most worksites fails to take into account the conflicting demands of home and family on the one hand and the demands of the job on the other hand. Most women are still occupationally segregated, occupying low-paying and low-status jobs, often part-time, with little opportunity for promotion and access to managerial or decision-making levels of power.

In order to have a healthy and productive workforce, there needs to be a fit between the individual's resources and capabilities and the demands and rewards of the job. This goal implies recognizing the dual demands of work and family responsibilities, finding the best person to fill the job regardless of gender, providing appropriate rewards for work done rather than rewards based on the gender of the worker, and providing opportunities for all workers to reach their full potential.

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CONTEMPORARY ISSUES FOR WOMEN IN THE WORKPLACE: A Sociological Perspective

PAULA BENNETT AND KATHLEEN HUMPAGE

The past 20 years have been a period of significant and dramatic changes with respect to the participation and aspirations of women in the paid labor force. As we enter the 1990s, however, considerable work remains to be done in order to achieve full equality in the workplace.

Among the most obvious changes in the labor force over the past 20 years has been the increased participation of women, who now comprise approximately 45% of the paid labor force. In addition, the length of time women spend in the paid labor force has been increasing and is now comparable to that of men.

As women have entered the labor force in increasing numbers, they have become aware of the wide range of career and employment choices that exist. In general, women have achieved higher levels of education and they have begun to train for and enter a wider range of occupations, including male-dominated or non-traditional ones. Changing patterns in education and labor force participation have resulted in changes in women's perception of their own roles and the range of choices available to them.

In the early 1960s, two-thirds of Canadian families consisted of a breadwinner husband and a wife at home. Today, fewer than one in six Canadian families fits this description. Overall, over half of Canadian

women are currently in the workforce, including a majority of Canadian mothers with children under 16.

Family composition has changed considerably over the past few decades, and there are greater numbers of single-parent and two-earner families. As two-earner and single-parent families have become more prevalent, the interaction between work and family life has become increasingly critical. Becoming a focal concern is the need to design ways for workers who must care for children, or for disabled and elderly family members, to meet these responsibilities.

The attitudes and perceptions that reflect the view that women's primary role is wife and mother persist despite the reality of women's participation and attachment to the paid labor force, and despite changing family characteristics such as the increased divorce rate, the growth of single-parent families, and the increase in two-earner families. While it is recognized that, for many women, childcare and family concerns are a major focus, it must also be recognized that, for these women and for others, the economic independence that results from equality in employment is an essential and necessary right. Such equality of access and opportunity can be achieved only when women's role in the paid labor force is fully recognized and accepted.

Women enter the paid labor force for the same reasons men do—personal fulfilment, the opportunity for success and achievement, and, most important, economic reasons. It is increasingly difficult for a family to make ends meet on one salary; in many two-earner families, the woman's salary is needed on a daily basis. Moreover, women are the sole support of over 80% of Canada's lone-parent families.

Women in the paid labor force face a variety of situations and concerns that are different from those faced by their male co-workers. In the next section we will examine three major issues affecting women's equal participation and opportunities in the paid labor force: the integration of work and family responsibilities, occupational segregation, and sexual harassment. The final sections will provide a brief discussion of some special measures to remove the barriers that prevent full equality in the labor force.

INTEGRATION OF WORK AND FAMILY RESPONSIBILITIES

Although both women and men have family responsibilities, more often than not it is women who carry the greater share of these responsibilities. It is a fact of life that women periodically leave the labor

force to have children and take time off work to look after the needs of infants and young children. As a result, many women miss out on employment and training opportunities and career development, and lose seniority and pension benefits. Moreover, their temporary absences or the prospect of their departure is too often viewed as evidence of a lack of commitment to their job in particular and to careers outside the home in general. In short, all too frequently women continue to be considered poor employment risks.

It is important that a network of legislative, policy, and program responses be developed to reduce the negative effects of family responsibilities on the employment situation of women and to promote an equitable, shared approach to childcare.

Pregnancy and childcare leave and benefits are among the key provisions that recognize the reality of workers' dual responsibilities and provide ways of balancing them. All labor standards legislation in Canada provides for unpaid pregnancy leave, in most cases 17 or 18 weeks. Leave provisions in the jurisdictions vary in terms of duration of leave, qualifying period, notice requirement, benefits and reinstatement, and employee coverage.

In addition to pregnancy leave, employees under federal jurisdiction are entitled to 24 weeks of unpaid childcare leave, which is available to either parent, natural or adoptive. Employees who avail themselves of pregnancy or childcare leave must be notified of employment opportunities during their absence to allow them to make choices concerning the optimal time to resume employment activity. Specific adoption leave provisions are provided as well in the employment standards legislation of a number of provinces, and several have also legislated unpaid paternity leave for fathers with newborn children.

Women on pregnancy leave and parents who adopt a child may be eligible to receive benefits through the Unemployment Insurance program. (The federal government has proposed changes respecting parental benefits effective January 1, 1990.) Benefits exceeding those set out in legislation may be available to workers covered by collective agreements or by the human resource policies of certain employers.

In order to ensure the possibility of all parents' participating equally in the labor force, there is a need for available, accessible, affordable, flexible, and above all quality childcare arrangements. The absence of such childcare is a barrier to women's full participation in the

workforce and influences the type and quality of work they can accept. Childcare policies can promote equality in employment in a number of ways:

> by facilitating the labor force participation of females; by enabling them to work full-time as opposed to part-time; by expanding their choice of jobs beyond those that provide proximity to their household ... and by reducing their career interruptions and withdrawals from the labor force that prevent them from acquiring continuous work experience. (Gunderson, 1983, p. 55)

The importance of recruiting and retaining a qualified female labor force has recently prompted some employers to undertake initiatives related to childcare both on and off site, and it is expected that more employers will undertake these types of services in the coming years.

The economic pressures that have spawned the significant growth of two-earner households over the last few decades and the necessity of combining work and family responsibilities are among the major reasons given to explain the recent sharp increase in part-time employment. Part-time employment, which is a predominantly female phenomenon, now accounts for over 15% of employment in Canada.

As we head into the 1990s, many women working part-time do not want to work full-time for various reasons including family responsibilities, school attendance, and time and lifestyle flexibility. Correspondingly, from the employers' perspective, particularly in the rapidly expanding service sector, part-time employment is a very effective and efficient way of responding to short-term fluctuations in the demand for services.

However, despite the significant overall advantages of part-time employment for employers and employees in particular circumstances, there is concern that an increasing segment of part-time work is involuntarily so: over one in four women report that they are working part-time simply because they cannot find full-time jobs. As well there is a wage gap between full- and part-time employees; part-time workers are also less likely to have access to benefits such as health and disability insurance plans; and part-time workers are frequently excluded from participation in training programs and may be denied promotional opportunities available to full-time workers. The challenge is to find a way to reconcile the desire of employers and employees for part-time work schedules with the need for equitable wages and benefits for part-time workers.

Flexible work schedules, such as flexible hours of work, compressed work-week schedules, and job sharing, may provide a means for employees to integrate work and family responsibilities by allowing workers to maintain their labor force attachment and still care for family members. Employers often provide such schedules to improve employee morale, retain a qualified workforce, and reduce absenteeism. However, like part-time work, there may be serious drawbacks for employees such as lower pay and lack of benefits, and in some instances a reinforcement of the woman's responsibility to juggle the dual roles of worker and mother. The desire for flexible work schedules may also reinforce the belief held by some people that women have a weaker attachment to the labor force.

SEXUAL HARASSMENT

Sexual harassment in the workplace is a serious problem for women because it undermines their ability to achieve economic independence. A work situation in which there is sexual harassment results in intolerable conditions in the employment, training opportunities, and career progressions of the victims. If a woman is subjected to sexual harassment, she is unable to participate fully and equally in employment.

Sexual harassment is any conduct, comment, gesture, or contact of a sexual nature that is likely to cause offence or humiliation to any employee; or that might, on reasonable grounds, be perceived by that employee as placing a condition of a sexual nature on employment or on any opportunity for training or promotion. In many cases the person is able to let the harasser know that the behavior is unwanted and unacceptable; however, sexual harassment may also occur in cases where a reasonable person ought to have known that the behavior is unwanted and unacceptable without being explicitly informed.

Sexual harassment is not flirtation or other mutually acceptable behavior that may be part of the working environment. Incidents of sexual harassment range from insults directed at a person's gender, suggestive comments or language, and demeaning remarks to unwelcome touching and grabbing and other physical assaults.

Although no Canadian studies have been carried out specifically on the incidence of workplace sexual harassment, some informal surveys have been conducted. In 1983 the Canadian Human Rights Commission sponsored a study of the frequency of all kinds of "unwanted

sexual attention." Approximately half of the women surveyed reported that they had experienced some form of unwanted sexual attention at some time. On the basis of responses to that study, it can be estimated that well over one million Canadian women would identify themselves as victims of sexual harassment.

According to the Canadian Human Rights Commission survey, harassers are almost evenly split between supervisors and co-workers. While supervisors have the direct power to withhold jobs, benefits, or opportunities as retaliation against harassment victims, co-workers can make cooperative work difficult or impossible. Both supervisors and co-workers can create a stressful or hostile work environment that interferes with productive work. In addition, customers or clients who harass workers create an additional strain.

Sexual harassment has been recognized as a serious barrier to equality for women in the workplace. In order to address the situation, federal and provincial governments have enacted legislation that prohibits sexual harassment in the workplace. In addition, recent court decisions have determined that employers are required to ensure an employment situation free of sexual harassment. In particular, the Robichaud decision (Canadian Human Rights Reporter, 1987) found that employers are liable for the discriminatory acts, in this case sexual harassment, of their employees in the course of their employment. Information campaigns to ensure employers' awareness of their obligations and employees' awareness of their rights and avenues of redress are an important means of eradicating persistent inequality of women due to sexual harassment.

OCCUPATIONAL SEGREGATION

Women in the paid labor force are still employed mainly in sales, service, clerical, and health-related fields. The largest segment of the female labor force remains in clerical and related occupations, with women comprising over 70% of those employed in this area. In general, women are overrepresented in a narrow range of occupational groups in lower-paid, lower-status jobs.

As well, the majority of occupations and industries in which women are concentrated are not unionized. Unionization is especially weak in the sales and service sectors, banking, and, with the exception of the public service, clerical and office work. Generally speaking, wages and benefits in non-unionized sectors are inferior to those in unionized

sectors. In addition, non-unionized workers, who are not covered by increases negotiated in collective bargaining, may fall even further behind.

A number of reasons have been suggested to explain the continued concentration of women in a narrow range of jobs in occupational groups and sectors that are characterized by low pay and low prestige. These include type of education and the demands of family responsibilities.

Occupational segregation can be attributed in large part to the type of education and training that women receive. Women are still overrepresented in programs such as household sciences, education, nursing, rehabilitation medicine, secretarial science, and social work. Women have been slow to enter the traditionally male-dominated fields, both in formal education and in government-sponsored training programs. This pattern results in part from the fact that young women are still encouraged, through sex-role socialization by parents, peers, schools, and the media, to enter traditionally female courses and occupations. Although recently there has been some increase in female participation in fields such as administration, natural sciences, engineering and mathematics, and the social sciences, women generally still follow courses of study that lead to lower-paying female-dominated jobs with little opportunity for occupational mobility.

Occupational segregation can be combated by promoting the movement of women from female-dominated categories into traditionally male fields. Once access to all occupations is available on an equal basis, gender-based occupational segregation will diminish and attitudes regarding the "appropriateness" of certain occupations for men or women will be changed.

Income inequality is the most important consequence of occupational segregation. Recent data reveal that women earn on average two-thirds of what men earn on average. This persistent wage gap between men and women can be largely attributed to the fact that many women work in low-paid, low-status occupational groups and sectors.

Equal pay for work of equal value or "pay equity" legislation addresses the gender-based wage gap resulting from occupational segregation and the historical undervaluation of the work done by women. The legislation provides a mechanism for evaluating "women's work" and "men's work" on the basis of specific factors: skill, effort,

responsibility, and working conditions. In this way, women who are doing work that is different from that done by men, but of equal value to the employer, will receive equal pay. As jobs start to be evaluated on their content, rather than on the gender of the occupant, gender-based occupational segregation should have minimal impact on wage determination.

Programs focused on recruiting, training, and promoting women are also essential to furthering their equality in the workplace. Employment equity programs can ensure equal access and equal opportunity for women (and others in designated groups) in occupations and employment in sectors in which they have been traditionally underrepresented. Training and retraining programs can assist women to find jobs in non-traditional areas and to deal with and benefit from technological change. It is important that women be prepared to take advantage of the employment opportunities that can emerge from the changes in the content and form of jobs resulting from advances in technology.

CONCLUSION

The increased labor force participation of Canadian women has dramatically and permanently changed the nature of the workplace and the focus of contemporary societal issues. As we move into the 21st century, all the partners to social change must resolve that action can and will be undertaken to ensure the removal of barriers to equity in the workplace.

Equality of opportunity and treatment for women and men workers can be achieved through the successful implementation of a number of strategies to eliminate the continuing inequality in the labor force. These kinds of measures, such as equal pay for work of equal value and training for women in non-traditional occupations, are perhaps the most obvious and direct in improving women's access to a full range of job opportunities. However, changes to the traditional perceptions of women's and men's roles and changes in the work environment are also needed to ensure that women can benefit fully from new job opportunities.

The right to a safe and healthy work environment is an essential element to allow women to participate equally with men. In this regard, policies designed to eliminate sexual harassment in the workplace are very important, as sexual harassment can threaten present and future job prospects.

As suggested above, one of the principal barriers to women's full participation in the paid labor force is the disproportionate responsibility they continue to bear for the well-being of the home and family. Policies and programs are needed to encourage the sharing of family responsibilities, including such provisions as paid leave for family responsibilities (care for children and other family members), in addition to paid pregnancy, paternity, adoption, and parental leave. Flexible and alternative work patterns and arrangements may also enable workers to better integrate work and family responsibilities.

In the long run, however, the key to equality in the workplace will be a change in attitudes and perceptions concerning the roles and responsibilities of women and men. This requires education that is free of gender bias and emphasizes that men and women have a wide range of occupational choices and opportunities.

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WOMEN AND CURRENT SOCIAL ISSUES

FAMILY POLICY IN CANADA: From Where to Where?

MARGRIT EICHLER

Families in Canada have always displayed some variability. In societies in which we find important social changes, these changes inevitably have some effect on families, for the simple reason that people are affected by such changes and that these same people are likely to live in families. Families in Canada have, therefore, never been static structures, and they have never been all of the same kind (Nett, 1981). The nuclear family in which father, mother, their own biological children and nobody else lived happily together has always largely been a myth: families were not necessarily happy just because they lived under the same roof; and there have always been family disruptions for reasons of death and desertion, as well as migration because of economic necessity.*

Nevertheless, there are times in which changes are particularly

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* For American data, see Mary Jo Bane, "Marital Disruption and the Lives of Children,"in George Levinger and Oliver C. Moles (Eds.), *Divorce and Separation: Context, Causes and Consequences* (New York, Basic Books, 1979, pp. 276-286). For a historical Canadian example see Tamara K. Hareven, "The Dynamics of Kin in an Industrial Community," in *The American Journal of Sociology* (1978, 84, pp.5151-5182). See also R. Pike, "Legal Access and the Incidence of Divorce in Canada: A Socio-Historical Analysis," *Canadian Review of Sociology and Anthropology* (1975, 12, pp. 115-133).

marked, and in which one pattern is being visibly replaced by another pattern. I will argue in this paper that we are currently living in such a period where one type of family pattern is being replaced by another one, without the process having been completed. In the next section, I will briefly describe some of the prominent features of contemporary Canadian families. I will then construct a model of what I call the "old" family, which represents a simplified theoretical construction of what was. Following this, I will construct a model of the "new" family, which is a simplified hypothetical construction of where I see us, as a society, moving, and I shall locate our contemporary families somewhere between these two end points.

I shall then look at social policies that are appropriate for the "old" model of the family, and thereafter at those that are appropriate for the "new" model of the family, and I shall note the fit (or lack of fit) between the micro and macro levels. Lastly, I will briefly discuss some of these considerations for law.

DESCRIPTIONS OF CONTEMPORARY FAMILIES IN CANADA

Recently, there have been some major changes in Canadian households and families, which can be addressed under the headings of (a) demographic changes, (b) changes in the nature of economic cooperation, (c) changes in awareness with respect to family violence, and (d) consequences of (a) and (b).

Demographic Changes

One of the most striking changes we can observe is the decrease in fertility. Canadian women have fewer children than ever before. Whereas in 1960 the average number of children per woman was about 3.9, in 1985 it had sunk to less than 1.7 (Eichler, 1988). *That is, fertility has decreased by more than half in a quarter-century.*

Life expectancy, by contrast, has risen constantly. For a male born in Canada in 1931, the life expenctancy at birth was 60 years, and for a female born in that year, it was 62.1 years. For a male born in Canada in 1976, the life expectancy is 69.6 years, and for a female born in that year, it is 76.9 years (Statistics Canada, 1979). Barring unforeseen disasters of a national scope, one would expect the life expectancy to continue to rise in the future. This trend means that there will be more older people around who will eventually need to be taken care of, and fewer younger people to provide the care. In terms of family relationships, there are

likely to be more grandparents alive during the youth and young adulthood of their grandchildren, and fewer grandchildren per grandparent.

The divorce rate has increased steadily and consistently over the past decades, rising from a rate of 39.1 per 100,000 in 1960, which represents 6,980 divorces in that year in Canada, to a rate of 308.8 per 100,000 in 1986, which represents 78,160 divorces (Statistics Canada, 1989). This steep increase follows a small decline during the years 1983-85 (Eichler, 1988) probably due to the speculation around the introduction of a new divorce law. The new divorce law took force in July 1986, and divorces went up. *Indications are that for the time being the divorce rate will continue to climb.*

Owing to the great increase in divorce, there has been a great increase in remarriages. In 1986, 30% of all marriages contracted in that year involved at least one previously married partner, compared to 12.3% of all marriages in 1967 (Statistics Canada, 1989).

The great bulk of that increase is due to divorced rather than widowed persons remarrying; indeed, the proportion of widowed persons remarrying has consistently declined, no doubt because of the increased life expectancy. One would expect this trend to continue for as long as the divorce rate remains high or increases.

Further, there has been a large (although inconsistent) increase in the percentage of births to unmarried mothers. Wherease in 1960 only 4.3% of all children were born to unmarried women, representing 20,413 children, the percentage has risen to 18.7% in 1986, representing 68,308 children (Statistics Canada, 1989).*

One consequence of the increase in divorce and in births to unmarried women is that the proportion of children living in one-parent households has increased. Approximately 17% of all families with children consisted of one-parent households in 1981, mostly headed by women (Economic Council of Canada, 1983). About 40% of these female-headed families were poor in 1986 (National Council of Welfare, 1988).

Changes in Economic Cooperation

It used to be the case that women dropped out of the labor force

* For comparative data on illegitimacy rates, divorce rates, and labor force participation rates of women, see Eichler (1984). For comparative rates of fertility and other factors, see Inkeles (1980).

when they married. In the 1960s, the prevalent pattern was that they remained in the labor force after marriage until the birth of the first child, at which time they dropped out, sometimes to return after the last child had entered school (Ostry, 1968).

The labor force participation of married women has increased consistently (Eichler, 1988), and today the majority of Canadian wives are in the paid labor force. We have thus crossed a threshold (at around 1980) that changes the majority pattern for husband/wife families from a breadwinner family to a two-earner family.

A corollary of this change is that the majority of Canadian children now have a mother who is in the paid labor force, although wives and mothers are, of course, not an identical group (Eichler, 1988).

Changes in Awareness of Family Violence

Until quite recently, violence within families was effectively hidden. It is only since the mid-1970s that some consistent scholarly and public attention has been focused on this problem. As a consequence, we have no reliable information about the incidence of any form of family violence in the past, and very little information about the incidence and its nature in the present. This lack makes any statements about changes in any type of familial violence impossible, since there is no basis against which to assess contemporary information (to the degree that it exists).

The editors of one of the most recent comprehensive American books on family violence conclude:

> The family is the predominant setting for every form of physical violence from slaps to torture and murder. In fact, some form of physical violence in the life cycle of family members is so likely that it can be said to be almost universal.... If this is indeed the case, then violence is as typical of family relationships as is love. (Hotaling & Strauss, 1980, p.4)

There is no reason to suspect that Canada would fare any better if we had a representative study of violence within families in Canada. One usual estimate that is often cited is that 10% of all Canadian wives are being battered by their husbands (common law as well as legal) (MacLeod, 1980).

As for sexual abuse of children, the Committee on Sexual Offences Against Children and Youths found in a national population survey that 30.4% of all men and 53.9% of all women reported that they

had been victims of sexual offences, ranging from unwanted exposure to a sexual attack. Looking only at the most serious form of assault, namely whether anyone had ever tried to have sex with them or had forcibly sexually assaulted them, the committee found that 22.1% of the women and 10.6% of the men had experienced this form of assault (Report of the Committee on Sexual Offences Against Children and Youths, 1984).

The committee concluded in terms of changes in incidence that:

> The best evidence available ... suggests that the volume of these crimes in relation to population growth has remained at a relatively constant level for some time. In this respect, the major change that appears to have occurred is not so much an alteration in the incidence of these offences, but the fact that Canadians as a whole are becoming more aware of a deeply rooted problem whose dimensions have not significantly shifted in recent decades. (p. 185)

Finally, the committee found that well over half of all actual assaults occurred in the homes of victims or suspects, and that the majority of the assailants were already known to and possibly trusted by the assaulted victims. Thus sexual assault is placed well within the circle of the family.

Consequences of Demographic Changes and Changes in Economic Cooperation

Given the noted increases in divorce, unmarried motherhood, and remarriage, we find an increasing separation between marital and spousal roles. This shows itself in a high proportion of households in which dependent children live together with only one of their biological parents, while the other biological parent is still alive but living in another household; moreover, either one or both biological parents may have remarried a spouse who thus becomes a wife or husband but not a biological mother or father to the children involved. Whether or not the children concerned actually experience such a "stepparent" as a social parent seems to vary greatly (Gross, 1985).

It is not the fact of stepparenting that is startlingly new, but the scope of the phenomenon as well as the continuing existence (and often involvement) of the non-coresidential parent in the parenting process.

Another consequence of these same factors, simply stating the same facts differently, is a large (and increasing) incongruity between household and family membership. In other words, within one house-

hold, it is not necessarily the case, for each member of the household, that the same individuals are members of her or his family. Imagine a family with two children, in which the husband and wife (who are father and mother to the children) divorce; the father maintains contact through visiting arrangements with his children; the mother has custody and the children reside with her. In that case, the mother and the children form one household, and for the mother, they form her family; however, the children have family members in two households, namely their own and their father's.

Now let us assume that the father marries another woman who also brings a child from a previous union into this marriage, and that eventually the father and his new wife have another child together. The children of the first family now have a half-sibling and a step-sibling, as well as potentially a stepmother, in their father's household. However, the child whom the father's second wife brought into the marriage also maintains contact with his father. This example can be continued by assuming that the first wife also remarries (a man with or without children), that the previous partner of the second wife remarries, and so on. It is, however, sufficient to illustrate the point that household membership and family membership are no longer necessarily congruent, and that as a consequence members of one household may have different family members.

This kind of pattern opens up new sets of relationships that did not previously exist to the same degree, as well as creating problems in relationships that also did not previously exist to the same degree. Children who are not biologically related may nevertheless be step-siblings and share half-siblings. Parents of an adult child who marries a partner with children from a previous marriage may find themselves in a quasi- or step-grandparental relationship to those children. On the other hand, parents of an adult child who divorces and loses custody may have difficulty maintaining contact with their grandchildren.

As a consequence of the changed pattern of economic cooperation, we can note that a shift has occurred from the breadwinner couple to the two-earner couple as the norm, and that at the same time the full-time mother has become a minority phenomenon and that the majority of Canadian children experience some form of shared childcare.

Finally, we note that because of a number of factors, a large proportion of women and children are living in poverty. This situation

is due to the high proportion of one-parent households, noted above, in the vast majority of which the head is female. Not only do women generally have lower-paying jobs than men, but maintenance payments from fathers are generally exceedingly low, not reflecting real costs of providing for a child let alone childcare (Dulude, 1984). Moreover, our child-related benefits are low by comparative international standards (Kamerman & Kahn, 1978, 1981), and our social welfare legislation actively discourages the changeover from a poor female-headed household on social assistance to a husband/wife family with somewhat higher resources (Eichler, 1984).

To sum up, Canadian families today are characterized by a wide degree of differences in terms of composition, structure, and type of economic cooperation (or lack thereof), with quite divergent consequences for different families. There are one-parent and two-parent households, and households in which husband and wife are not joint parents to all or some children involved. There is an increasing separation between marital and parental roles, and increasing incongruity between family and household memberships. With a majority of wives in the labor force, the husband-breadwinner family is in the minority. We find an increase in the proportion of one-parent households. The majority pattern for Canadian children today is to not have a full-time mother at home and therefore to experience some form of shared childcare. It should be added here that only a small minority of these children find places in a licensed, supervised daycare setting. The majority of them are cared for in unlicensed, unsupervised settings, where the care ranges from excellent to appalling (Eichler, 1988; Canadian Advisory Council on Status of Women, 1986).

Finally, a large number of women and children find themselves in or near poverty.

It should be noted that Canada is not alone in experiencing these trends. At least some of them seem to be causally connected with the process of industrialization, since we find similarities in familial structures among all highly industrialized countries. The demographic changes noted in Canada can also be observed in other highly industrialized countries, as well as a trend for women to participate in the paid labor force (and therefore presumably for wives and mothers to participate in the paid labor force) in large numbers. Overall, we can also note a large discrepancy between household and family membership, as suggested by internationally high divorce rates and illegitimacy rates. It

is interesting to note that these trends are observable in all highly industrialized countries, irrespective of political regime: they are equally found in Eastern Europe as well as in Western Europe, North America, Japan, New Zealand, and Australia (Eichler, 1984; Inkeles, 1980).

Clearly, then, we are in a period of considerable social change as far as familial structures are concerned. It now becomes important to attempt to identify the direction of the ongoing changes, especially if we wish to assess the adequacy of policies affecting families, now and in the future

THE "OLD" AND "NEW" MODEL OF THE FAMILY

Mary Ann Glendon (1980) has argued that we are currently in a period of "unsettled assumptions" about marriage. She suggests that we are moving towards a "new marriage," which is complemented by a "new property," both of which are the result of a complex shift in the relative importance of family, work, and government as status determinants and sources of support. She characterizes the "new marriage, American Style" as having

> two earners, mutually dependent on their combined sources of income, the wife earning less than the husband. The wife's earnings, though low, seem, together with her earning potential, to be a major factor that makes it easier for husbands as well as wives to depart from a marriage.... Since three out of four divorced persons remarry, the new marriage is often a subsequent marriage.... Thus, one can fairly say that in the United States, there is now a fundamental right to marry, and marry and marry. (Glendon, 1980)

Building on this analysis, I shall attempt to develop a model of the "old" family and of the "new" family (rather than the "new marriage") since, as far as social policies are concerned, it is the entire family (including the children) that should be considered as of central importance. If the above summary trend is correct, and there is indeed a growing dissociation between marital and parental roles, then obviously this aspect must be systematically integrated into any consideration of the adequacies of social policies.

After having presented models of the "old" and "new" family, I shall develop models of social policies that correspond to the "old" and the "new" family at the macro level, if we assume that there was congruity between behaviors at the micro level and assumptions about such behaviors as displayed in policies at the macro level. This will then

allow us to place current familial styles of behavior somewhere on a continuum between "old" and "new" families, and to assess the degree of congruence (or lack thereof) of current social policies in view of the placement of contemporary Canadian families on the old-new continuum.

The Model of the "Old" Family

I shall structure the discussion in terms of four dimensions: ideology, economy (in terms of responsibility and dependency), household composition and management, and personal care.

As far as the ideological dimension is concerned, the old family is characterized by a very strong sex-role differentiation that affects all other dimensions. The roles of wives and husbands, fathers and mothers, are clearly distinguished and largely non-overlapping. This differentiation is manifested in the assignment of economic responsibility and household management as well as in the responsibility for personal care. The father/husband is seen as responsible for the economic well-being of the entire family, while the mother/wife is seen as responsible for the physical, emotional, and overall well-being of family members. Her role includes providing care to family members in need of care, including sometimes aged parents. By corollary, the father/husband is not seen as responsible except in economic terms, while the mother/wife is not seen as responsible for the economic well-being of the family.

Wife and children are thus conceptualized as economic dependants of the husband/father, and the work that wives perform within the household as full-time or part-time homemakers is for that reason necessarily invisible with respect to its economic value (Eichler, 1985). If wives or mothers are in the labor force, their work is in addition to their homemaking functions and earnings are seen as of secondary importance.

As far as household composition is concerned, the nuclear family, consisting of a husband, wife, and their own biological children (and nobody else), is seen as normative. As a consequence, household and family memberships are treated as congruent. Further, there is an unclear division between spousal and parental obligations, and as a consequence, wives are equated with mothers, and husbands are equated with fathers, while parents who are non-coresidential with their children are treated as non-parents.

The old model of the family can be summarized as follows:

THE "OLD" FAMILY MODEL

Ideology	Sex-role differentiation
Economic responsibility	Husbands/fathers as breadwinners, wives secondary earners or non-earners
Economic dependency	Wives/children as dependants of husbands/fathers
Household composition	Assumption of congruence between household and family membership
	The nuclear family seen as normative
	Wives equated with mothers, husbands equated with fathers
Household management	Wives/mothers as full-time or part-time homemakers with sole responsibility for household management
	Husbands/fathers not responsible for household management
	Unclear distinction between spousal and parental obligations
Personal care	Mothers/wives/adult daughters (-in-law) responsible for provision of care for children and adults
	Fathers/husbands/sons (-in-law) not responsible for provision of care for children and adults

The Model of the "New" Family

By contrast with the "old" family, the "new" family is premised on the notion of sex equality rather than sex-role differentiation. This premise applies to all dimensions of interaction. Consequently, the roles of husbands and wives, mothers and fathers, are not differentiated on the basis of sex but on the basis of individualistic factors, and they overlap to a high degree. Household management as well as economic responsibilities are shared by husband and wife. Both father and mother are seen as responsible for the economic, physical, emotional, and overall well-being of the various family members.

Children are seen as the economic dependants of both mother and father, and both wife and husband are full-time participants in the labor force and are in addition responsible for the housework.

Male relatives are co-responsible with female relatives for the care of family members in need of care.

As far as household composition is concerned, variable structures are recognized as constituting different types of families. A potential incongruity between spousal and parental roles due to unmarried motherhood, divorce, remarriage, and other factors is acknowledged and accepted. Consequently, there is a clear distinction between spousal and parental obligations, since husbands are not necessarily equated with fathers, wives are not necessarily equated with mothers, and non-coresidential parents are recognized as such.

The model of the "new" family can be summarized as follows:

THE "NEW" FAMILY MODEL

Ideology	Sex equality
Economic responsibility	Husbands and wives (fathers and mothers) are both earners, equally responsible for their own support and that of the children
Economic dependency	Children are dependants of their mothers and fathers
Household composition	No assumption of congruence between household and family members
	A variety of family types acknowledged and accepted
	Wives not unquestioningly equated with mothers, nor husbands with fathers
Household management	Shared responsibility between husband and wife
	Clear distinction between spousal and parental obligations
Personal care	Mothers/fathers, wives/husbands, daughters/sons, daughters-in-law/sons-in-law equally responsible for provision of care for

family members in need of care to the degree that this can be combined with full-time paid work

SOCIAL POLICIES APPROPRIATE FOR THE NEW AND OLD FAMILIES

In this section, we will consider each of the items of the "new" and the "old" family and consider what type of social (including economic) policy would be appropriate to each of the models of the family. In order to be able to do so, we need to shift our attention from the micro level to the macro level and consequently translate some of the dimensions employed at the micro level to those appropriate for the macro level.

The ideological dimension remains such, but the economic dimension, which was split into responsibility and dependency for the micro level, needs to be split into labor market policies, the tax structure, and other government transfers for us to consider some of the implications of the "old" and "new" models of the family. Household composition remains as a dimension, and personal care translates into social services. Household management (i.e., unpaid housework) is integrated as a tacit assumption into labor market policies, the tax structure, other government transfer programs, and social services.

In the following section, I shall consider which policies are logically congruent with both the "old" and the "new" models of the family.

Policies Congruent with the "Old" Family

As far as the ideological dimension is concerned, policies must obviously be based on the notion of sex-role differentiation in order to match the "old" model of the family. Therefore, for the purpose of labor market policies, men are treated as the primary earners, and women as the secondary earners or non-earners. Since women are seen as solely responsible for household management, it follows that men, whether they do or do not have a family, are seen as completely unencumbered by family responsibilities, while conversely all women with families are seen as encumbered by family responsibilities or, if without family, seen as potentially encumbered depending on age and other characteristics (such as the assessed likelihood to get married or to have a child). Only

if, in the eyes of an employer, a woman is highly unlikely to ever acquire a family of her own, could she possibly be considered as a worker of equal value to a male worker, but since she, by definition, does not have dependants, therefore she requires a lower wage than a comparable male worker.

The tax structure will, logically, provide some tax relief to the man who has dependants (such as a wife and children), for example via a spousal exemption.

Other government programs will provide replacement income in case of the incapacity or absence of a male breadwinner. Social assistance programs, for example, will provide financial assistance to mothers with dependent children but without a man to depend on, but will withdraw such assistance when a man who is theoretically capable of earning an income assumes some aspects of a husband role. Since husbands are equated with fathers, this a logical policy to pursue. By contrast, if a wife's earnings cease, the loss of income will not entitle the family to a replacement income.

Conversely, when a wife/mother is incapable of providing care to family members by reason of incapacity or absence, the state will provide replacement service. By way of example, when a wife or mother is unable to do housework because of a serious and prolonged illness, the provincial hospital insurance plan may provide a substitute homemaker, but will fail to do so when a man is incapacitated or absent and therefore cannot do housework, irrespective of whether he had or had not done it before he became incapacitated.

As far as household composition is concerned, the assumption underlying policies is that membership in a household is identical with family membership and, conversely, that there are no nuclear family relationships of importance between households. There will be little concern, then, with enforcing the economic responsibility of parents (predominantly fathers) towards their dependent children if they no longer (or never did) reside together with them, for whatever reason.

With respect to social services, women are assumed to be available for the care of family members in need of care, whether these women do or do not have paid employment (which is always of secondary importance compared to their family responsibilities, while the reverse is true for men). Accordingly, there is no societal reason for providing childcare for husband/wife families, since the wife is (and if

she is not, she should be) available to look after the children; nor is there much concern with providing care for people who need care but who have mothers, wives, adult daughters, or daughters-in-law nearby.

We can summarize policies appropriate for the old model of the family as follows:

POLICIES CONGRUENT WITH THE "OLD" FAMILY MODEL

Ideology	Sex-role differentiation
Economy:	
Labor market policy	Men seen as primary earners, women as secondary earners or non-earners
	Preference is therefore given to men over women in all employment programs, women are treated as labor force reserve
	A large wage differential by sex
	Employers and labor law regulations treat male workers as unencumbered by family responsibilities, and female workers as encumbered or potentially encumbered
Tax structure	Provides relief to male earners with dependants (i.e., wife and/or children)
Other government transfers	Provide replacement income in case of absence of male breadwinner or presence but incapacity to earn income
	Provide replacement care in case of incapacity or absence of wife/mother
Household composition	For purposes of eligibility for benefits, household membership is equated with family membership, and eligibility is determined on basis of family need rather than individual entitlement
	Rights and obligations of non-coresidential parents are not enforced
Social services	No universal daycare, no universal relief for care of adult family members in need of care, no institutionalized right to care for temporarily sick family members on the part of workers

Policies Congruent with the "New" Family

If policies appropriate for the "old" family—"old" policies, so to speak—are premised on the notion of sex differentiation in the ideological dimension, policies appropriate for the "new" family—"new" policies— must be premised on the notion of sex equality. From this premise a large number of consequences flow for all other social policies.

With respect to the economy, and for purposes of labor market policy, women and men are treated equally as primary earners, all employment programs are equally targeted towards women and men, there is no wage differential on the basis of sex, and employers as well as labor law recognize that the vast majority of workers—male as well as female—do have some familial relationships and therefore do have some responsibility towards their family members. There is no difference on the basis of sex in the manner in which these familial responsibilities are recognized and accepted.

The tax structure provides relief to parents with respect to the costs attached to rearing children, but adults are not conceptualized as dependants of other adults.

Other government transfers provide replacement income and replacement care in case of incapacity or absence of one parent (either mother or father).

For the purposes of government programs, variability in family structures is recognized and accepted. In other words, household membership is not automatically equated with family membership, and ongoing parental responsibilities of non-coresidential parents are continuously enforced.

As far as social services are concerned, it is recognized as being in principle impossible for any person to be responsible for his or her own economic welfare and therefore to have a full-time paid job while at the same time being responsible for a person in need of care on a full-time basis, such as a dependent child or an adult in need of care. Therefore, there is a system of social services that through a network of services provides care for children as well as for adults in need of care. Alternatively, there is a wage replacement system in place that reimburses adults who care for other people, including their own family members, for their losses in income. Labor law recognizes the right of paid workers to some paid time off for family responsibility, just as we now recognize the right to paid statutory holidays and vacation and sick leave.

We can summarize policies appropriate for the new model of the family as follows:

POLICIES CONGRUENT WITH THE "NEW" FAMILY MODEL

Ideology	Sex equality
Economy:	
Labor market policy	Women and men seen as primary wage earners
	All employment programs equally targeted to female and male workers
	No wage differential by sex
	Family responsibilities of male and female workers equally recognized and accepted
Tax structure	Provides relief to parents
Other government transfers	Provide replacement income and replacement care in case of absence or inability of one parent
Household composition	Eligibility for benefits is based on individual entitlement rather than family status. Household and family memberships are not equated unless in fact congruent
	Rights and obligations of non-coresidential parents are enforced
Social services	Wide network of social services for childcare and adults in need of care and/or wage replacement system for people caring full-time for family members

Placement of Contemporary Families and Policies on the Old-New Continuum

As we look at families in Canada today, it becomes obvious that at the micro level we have moved a fair distance towards the "new" family. Sex equality as an ideology is more often accepted than not; more wives are earning money than are completely economically dependent on their husbands; family laws have been amended to make both parents responsible for the economic well-being of their children as well as for their care and other housework; a variety of family types coexist although they are not always acknowledged or socially accepted; and the increase in remarriages has generated some awareness that spousal

and parental obligations must be distinguished, especially in dealing with the aftermath of divorce. We do not really know to what degree male relatives are involved in the care of their family members in need of care.

Nevertheless, it would be quite incorrect to say that as a society we have generally adopted the "new " family as the model of the family. That we are, at present, clearly in a transitional stage expresses itself in two different ways. For one, a substantial proportion of the population, in particular its middle-aged and older segments, were brought up while the old model was the accepted model of the family. These people must now cope with circumstances that have changed. Even if they themselves eventually adopt a new style of life, part of their history will remain tied up with the old model of the family. For instance, if a wife takes on full-time paid employment after she has been a homemaker for 20 years, she will never make up in seniority and pay what she lost in the time she worked as an unpaid homemaker.

Secondly, some people still choose to follow a modified version of the old model of the family in their own behavior. Although the majority of mothers work for pay, there are still substantial numbers of mothers who drop out of the labor force when their first child is born. Presumably, these people will eventually find themselves in a situation similar to that currently encountered by those of middle or older ages who have conformed to the old model of the family.

The presence of this second group of relatively young people means that we will remain in a transitional stage for at least another 30 years, because even when these women go into the labor force later on, most of them will not be able to catch up in areas such as career progress, acquisition of seniority, or income potential.

To the degree that women are less likely to be full-time members of the paid labor force, it makes sense for them to do more of the caring for family members, thereby continuing sex-role differentiation in the personal care dimension.

Nevertheless, we seem to be well on our way towards the new model of the family.

When we turn to policies, a totally different picture emerges. Our present policies are in general better described as policies more congruent with the old model of the family than with the new.

In spite of the fact that more women than ever before are cur-

rently in the paid labor force, sex segregation of occupations has not decreased in the recent past but may even have increased (Economic Council of Canada, 1983; Abella, 1984). Moreover, the wage differential between the sexes continues to be large. While there is a very limited (by international standards) acceptance that women have family responsibilities, there is hardly any recognition that men have family responsibilities, although paternity leaves can be obtained in some professions by male employees.* Parental leaves are, of course, only one component of recognizing family responsibilities of workers. A statutory right to time off in case of illness of family members would be another crucial aspect that is generally not available to either male or female employees at the present time in Canada, although such provisions do exist in other countries.

The tax structure provides some relief to parents, but also to breadwinners with dependants (the spousal exemption). Our social assistance programs tend to be largely premised on the notion of the "old" family. Eligibility for benefits is partially premised on family membership and partially on individual entitlement, and in general it is fair to say that the rights and obligations of non-coresidential parents (usually parents without custody) are inconsistently enforced (Dulude, 1984).

As far as social services are concerned, there is no wide public network available for childcare and care for adults in need of it. For instance, only a small minority of our children are cared for in public daycare settings, and the majority are in ad hoc private care situations.

These discrepancies present a serious problem. Our family structure has been changing quite rapidly, and as a consequence our social policies are "out of whack," since they have not changed at the same speed.

One of the many consequences of the mismatch between the "new" family and "old" policies is the increasing incidence of poverty among women and children, which has been noted earlier in this paper. Much of present-day efforts to further reform the family law can, in fact, be understood as an attempt to remedy this situation by sharing assets between ex-spouses more equally. In the last section of this paper, then, I shall in a rather cursory manner consider some of the implications of the above discussion for law.

* The recent revisions of the Unemployment Insurance Act have increased the likelihood of new fathers' having access to parental leaves.

IMPLICATIONS FOR LAW OF THE MOVE TOWARDS THE "NEW" FAMILY

Prior to the latest spate of revisions of the various family laws, which started with the enactment of the Ontario Family Law Reform Act in 1978, family law tended to be firmly based on the old model of the family. Laws were, as a rule, premised on the assumption of sex-role differentiation, the breadwinning role of the father, the homemaking role of the mother, female responsibility for the provision of care, and congruence between household and family membership which is perhaps most clearly exemplified in the notion of illegitimacy.

With the new legislation that has been enacted, the law has moved quite decisively in the direction of adopting the premises of the new family model. In practice, however, we are faced with some significant problems, because we are at present in a transitional period. Ex-wives and their children tend to fall into poverty upon divorce, whereas ex-husbands tend to be better off economically after divorce (Weitzman, 1985; Eichler, 1988).

While there are many other issues that are problematic and that can be traced back to this very basic disjunction between how people actually live together and how economic and social policies assume they live together, the desperate economic situation of many ex-wives and their children seems to be one of the issues around which a considerable amount of concern is focused. One of the major attempts to improve their situation can be found in a push for complete sharing of all assets (including business assets) between ex-spouses.

I see several problems with a full "community property" regime that would apply to everybody. If the foregoing analysis is correct, the major problem is located at the level of economic and social policies, and not primarily at the level of family law. Legal reformers might therefore profitably shift their attention to developing and implementing legal measures to improve the economic position of all women. Further, we must devise legal obligations and entitlements for men to discharge their part of familial responsibilities, so that the burden (and joy) of caring for others can, in fact, be shared between women and men. While this seems to be clearly the long-range direction to go, it must be acknowledged that there are many casualties due to the fact that we are in a transition period that will go on for a long time yet. In cases in which women entered a marriage under the old terms assuming that they

would be economically provided for, a community property regime would certainly be appropriate.

However, a compulsory community property regime for everybody would in principle reward women on the basis of their husband's economic contributions, not on the basis of their own work. That is, under the euphemism of "partnership," women would continue to be treated as their husbands' dependants. By contrast, I would argue that some women should get all the property—for instance, if they have raised children and also had a paying job—whereas other women who have not raised children, or cared for adults unable to care for themselves, and who have not had a paying job may not deserve half of all the property accumulated by the husband. And what do we do with wives who have supported husbands and done all or most of the housework as well as cared for others? Will they have to split their property with a man who has not contributed his share?

It seems somewhat ironic to me to argue for any one property regime for all families at the exact time when we are faced with a wide diversity of family types that will inevitably be with us for a long time to come. It seems also ironic to me to argue for ex-wives primarily on the basis of their spousal role, rather than on their spousal as well as their parental role, given that we are faced with an increasing dissociation between spousal and parental roles. In other words, the contributions of women as wives and as mothers should be separately assessed, just as the contributions (or lack thereof) of men as husbands and as fathers should be separately assessed. If a woman has by default borne all the responsibility for the parenting role, for the father as well as for herself, this contribution should be acknowledged in property settlements.

Nevertheless, economic equality for women will not come about by reforming the family law; it will come about by reforming labor law, revising our tax structure, and reshaping our economy. That is not to say that further reform of family law is unimportant, but merely to point out that it must not be seen as solving some problems that are beyond its purview. People who do socially useful work in their homes must be rewarded for this work socially, not privately; raising children must be seen as a social contribution, not only as a private contribution; and men and women must equally share family responsibilities in spite of their paid work, just as women must have the same access to jobs and the benefits attached to them as men have (Eichler, 1985). Once we achieve

these goals, ex-wives will not be so poor and children will not sink into poverty merely because their parents divorce or were never married in the first place.

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A LOOK AT THE REARGUARD OF THE VANGUARD: Employer-Assisted Childcare in Canada

DAVID NITKIN

Corporate support for working parents has moved beyond its infancy in Canada. The number of human resource department heads who believe (erroneously) that most households are the traditional two-parent male-breadwinner with at-home wife and children is declining. Key employees—those most worth recruiting or retaining—demonstrate strong interest in benefit packages that recognize childcare responsibilities. As well, all three federal political parties have proposed multi-year, national childcare funding programs.

In the words of Karen Liberman, a family issues consultant for corporations, "employer-assisted childcare is now at the readiness stage" in Canada. If growth over the last three years has been slow in absolute terms, it is large in relative terms. In short, corporations that wish to address this issue today are looking at joining the rearguard of the vanguard.

WHAT IS HAPPENING

Some 80%-85% of Canadian children receive informal or unlicensed care. They are cared for either at home (usually by a mother,

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relative, or parent aide) or in informal, unlicensed situations offered by a nearby neighbor, friend, relative, or babysitter. The remaining 15%-20% of Canadian children are cared for by the $2 billion annual licensed care industry. Within this second group, employer-assisted licensed daycare centres represent less than 4% of all childcare spaces in Canada. Their numbers, however, have doubled in Ontario and quadrupled nationwide in the last three years.

The major forces behind employer-assisted childcare are public institutions: hospitals, colleges, crown corporations, and government agencies. For-profit firms that employ over 500 workers directly sponsor only a minority (between 10% and 30%) of all employer-assisted, licensed childcare centres in Canada. The majority of all centres, whether sponsored by for-profit or not-for-profit corporations, are incorporated provincially as not-for-profit operations. Licensed, for-profit centres, located primarily in Alberta, Manitoba, and Ontario, are a sizeable minority of the total number of licensed spaces. Rarely are they affiliated with or their spaces paid for directly by Canadian employers.

THE CHANGING DEMAND FOR DAYCARE

Today, only 16% of Canadian households (and 10% of American ones) fit the traditional model of a two-parent unit, at-work father/breadwinner and at-home mother with children. Benefit planning must take into account a much greater diversity of household types, each with distinctive structures, parental roles, and needs. Today's workforce and family—so different and diverse from even a generation ago—includes two-parent/two-paycheque families, single-support parents (usually mothers, by a five-to-one ratio), and retired grandparents with childcare obligations.

The largest single group entering the workforce are women with children under 3 years of age. The number of working women, now 45% of Canada's 12.4 million employed labor force, has gradually increased by an average 1% per year since 1961. An estimated 80% of these employed women become pregnant at some time in their fertile years. It is little surprise then that many employers find valuable, well-trained employees in their late 20s, 30s, or early 40s faced with the stress of juggling career and family.

Almost half the nation's workforce comprises parents with children under 19 years of age. Half of all working women have a child under 6. These parents face a number of care support needs, both during

working hours and after school, in the evenings, and during holidays. Such needs go beyond traditional day and evening care requirements for infant, toddler, preschool, and school-age children. Parents seek near or at-home help for disabled or handicapped children who no longer are sent to an institution, for emergency care when sickness or death confronts the family, and for irregular care to accommodate unpredictable and irregular shift work. The leading edge of changing demand includes such services as telephone counselling programs for latchkey kids, care for children born with passive addiction to narcotics, and supervision of court-ordered visits by non-custodial parents.

WHY CORPORATIONS GET INVOLVED

Should employers take a role in childcare other than through normal employee remuneration?

For some employers, and their numbers are growing, the answer is yes. Some subsidize daycare centres or private-home daycare placements. Others underwrite the cost of information and resource services, including parent education or financial assistance not only for daytime childcare but also for infant care, after-school care, summer programs, emergency/sick care, and other work/family issues. Still others offer assistance in the form of flexible work schedules, alternative work arrangements, enhanced benefit packages and leave provisions, or flexible spending accounts, vouchers, and placement subsidies.

The principal reasons given for such benefits are to retain and recruit high-calibre employees, particularly in high-knowledge, low-labor-supply, or high-training-requirement positions. According to Martin Walpert, personnel director at CBS Records, his company identified a childcare quality and accessibility problem on the part of its employees. The firm joined forces with an already developing centre, the Global Playhouse Childcare Centre, in Toronto. Parents working for Global TV, Harlequin Books, CBS Records, and the North York Board of Education use this centre, in proportion to their employers' capital investment and support of Global Playhouse.

EMPLOYER-ASSISTED ON- OR NEAR-SITE CHILDCARE CENTRES

Public-sector employer-sponsored centres are most common in Ontario and Quebec. Hospital employees, who work long shifts and odd hours on irregularly scheduled days, turn to their employers for rent-free space with subsidized housekeeping and maintenance when they

discover that existing community programs don't meet their needs. At the PLADEC Day Care Centre, for example, the Kingston Psychiatric Hospital agreed to provide services such as rent-free space, utilities, and two hours daily of housekeeping, as well as laundry pick-up and building maintenance.

There are impressive, well-planned efforts in the private sector. The New Park Daycare, an at-work site at Magna International's industrial park in Markham, Ontario, supports the needs of parents at 23 area-wide Magna plants. The centre has been in operation since July 1986 and, according to director Wendy Campbell, provides 101 spaces for children from 6 weeks to 5 years of age.

The company contributes toward capital construction costs and part of the fees of parents, and nominates two representatives to the 12-person non-profit board that directs the centre. Planning for a second centre is in progress.

Having children at the workplace reduces travel time, anxiety, and stress as well as providing peace of mind for parents who visit their child during a workday. In this sense, says Tamara Brown, director of Hydrokids in downtown Toronto, "on-site care is good for the kids it serves." Her 62 licensed spaces have a long waiting list: a sure sign of the shortage of quality affordable spaces outside the home. The employer, Ontario Hydro, provides rent-free premises, ongoing janitorial and security services, utilities and routine maintenance, and an interest-free loan, as well as a $200,000 start-up capital grant.

Downtown locations must cope with many pressures, including steep rents, high start-up costs ($0.5 million over two to three years is not uncommon), and space restrictions (sites typically serve only 40 to 50 children). For these and other reasons, Hydrokids is relocating nearby as well as opening new suburban and ex-urban centres at the public utility's other sites outside the downtown core.

Accessibility is a critical factor in the search for reliable daycare. Consultants who advise corporations on family issues suggest that an employer with one or a few sites is better equipped to support an on- or near-site centre. Multiple-site companies often find it difficult to justify a single location as affording equally beneficial access for employees. An exception is the Southland Corporation's centre, established in 1984, which is located near a small head office in Vancouver. The company's 7-Eleven stores are located throughout that city.

In some cases the employer builds and operates the facility. More frequently, the company renovates space and turns over the deed to a registered not-for-profit entity created for that purpose. As well, the employer typically provides some maintenance, rent, interest-free loan, or related operational support. Parental involvement in management is seen as a way to help reduce overhead and fees while encouraging quality care.

Employers can cooperate in such ventures. The Global Playhouse Childcare Centre, which opened in September 1986, has its operating deficits shared in proportion to its four consortium partners' shares/spaces. According to Doreen Alrod, co-partner in the firm Childcare Consultants Alquin Inc. of Montreal, this "coalitional approach is very strong in Quebec."

Overall, the number of employer-assisted centres has grown rapidly in recent years. In Ontario, it nearly doubled in three years, from 27 in 1984 to 49 in July 1987. Small and medium-size companies (with under 500 staff) are often the principal participants of this type to date.

THE REFERRAL AND INFORMATION ALTERNATIVE

Daycare centres are an obvious but not the only choice for employers who support employee home/work needs. Many employers, after deliberation, choose an employee referral or parent information option.

Working parents seek more than just an income to support their children. They require reliable information about quality childcare options; assistance in finding, keeping, and paying for care; and flexible work schedules and benefits to help balance work and family responsibilities. The last is particularly important in the case of infant and school-age programs, which are often unavailable. When corporations do make a commitment in this area, many are willing to move beyond the step of just purchasing and photocopying a childcare directory for their employees.

Stresses such as illness, collapse of babysitting arrangements, teachers' professional development days, and searches for quality daycare take a measurable toll on attendance and productivity of working parents. More and more Canadian employers seek assistance from professional family issues consultants. In addition to providing direct counselling and referral information to parents, some of these consultants offer advice to employers on planning (needs survey assis-

tance, assessment studies, and identification of alternative options) as well as benefits (flextime, relocation policies, and parental leave). Employee referral services are less expensive alternatives to on-site daycare, which may not meet all parents' needs. The fee paid by the employer entitles parents to broad-ranging counsel and information as an employee benefit. The employee remains responsible for choosing and paying for the childcare selected.

Peoples Jewellers, headquartered in Toronto, provides just such a benefit. It pays a monthly fee (based on its number of employees) to the Childcare Advisory Line Ltd. so that staff have free access to those services. Jane Cockburn, childcare consultant at CALL, finds that their advisory line particularly appeals to corporations that have multiple sites, shift workers, or employees who commute long distances.

Most firms that specialize in offering such services have been founded within the last three years. Almost all are local or regional in scope and have fewer than five employees. According to Peter Ashmore at Information Daycare in Vancouver, his organization is beginning to develop what could become a national corporate services consulting program and daycare assurance plan in cooperation with Family Daycare Services in Toronto. Referral programs typically cost a few thousand dollars in year one and a subsequent annual fee based on employee use or the number of parents served.

Linda Barstow, senior consultant at Carousel Childcare Consulting Services, sees her company's strength as its ability to assess need and recommend placements for working parents from among a range of options: not-for-profit centres, licensed private home care, playgroups, co-op centres, and nanny agencies as well as summer camps and daycare and nursery programs.

Depending upon the particular plan chosen, employees may receive at-work and after-hours personal consultation as well as information and referral advice. These services help parents find and assess alternative care opportunities to meet their needs as well as provide support to parents whose children are already receiving childcare.

Barry Pipes, at Procter and Gamble, notes that his company is "very happy with the CALL service." It has been used "by and large successfully" by 25% of employees, which he says is most of those with children. The plan was implemented in connection with a move from a downtown to a suburban location as well as an office amalgamation. By

way of contrast, P&G's parent in Cincinnati has an in-house daycare program.

COMMERCIAL FOR-PROFIT DAYCARE

About 40% of Canadians who use organized daycare have children in private, for-profit daycare. The provinces, which have constitutional authority for childcare but share its funding with the federal government, offer different support programs to commercial for-profit centres. Most provinces make a number of grants, utilizing federal-provincial transfer payments, to co-ops or not-for-profit centres to encourage the creation and operation of parent-controlled, non-profit daycare. In certain larger municipalities, notably in British Columbia and south-central Ontario, subsidies are available to (but already fully utilized by) less well-to-do parents whose children are enrolled in commercial or not-for-profit centres.

Kinder-Care Learning Centers Inc., which operates more than 1,000 centres in the United States, is one of the few enterprises with more than ten sites in Canada. This contrasts sharply with the United States where enterprises like Children's World, Gerber Children's Centers, and La Petite Academy Inc. each operate over 100 (in the case of La Petite Academy, over 500) centres. Kinder-Care, in Canada since 1970, operates four Kinder-Care Centres in Manitoba and nine Mini-Skools in Ontario. Each offers programs for children from 6 weeks to 12 years old. According to Anne Fisher, district manager for Canada, attempts by Kinder-Care to enlist corporate involvement in their employer discount, fee-assisted Kindustry Program have been unsuccessful to date in Metro Toronto.

VOUCHERS, FINANCIAL ASSISTANCE, AND FLEXIBLE BENEFITS

Another difference from practices south of the border is the comparative reluctance to date of Canadian employers to use vouchers, subsidies, or other forms of direct financial assistance for childcare. The Conference Board (U.S.) reports that vouchers, discounts, flexible benefit plans, or flexible spending accounts represent fully 45% - 50% of all corporate-sponsored initiatives in this area.

One of Canada's earliest (and relatively still uncommon) voucher plans is in existence at the YWCA, Metro Toronto. The cash allowance was negotiated in response to a Canadian Union of Public Employees

demand that the employer provide support for staff required to work irregular and night shifts. The collective agreement calls for a childcare supplement of $30 per month for a first child and $10 per month for other children.

Canadian personnel directors and childcare consultants suggest that many employers just don't want this responsibility. Administratively, such payroll entries represent yet one more benefit negotiation and payroll processing item. In terms of legal liability, some companies do not want to appear to be supporting or recommending a particular childcare service. In addition, detractors of such plans suggest that such payments are discriminatory and could cause resentment among childless workers or those older ones who were able to cope years ago without such benefits.

Would existing, ineligible employees complain? "No," says Barry Pipes, "it's not a controversial negative." He notes that many benefits (such as a cafeteria or an Employee Assistance Program) are voluntary and selective. One such flexible benefits plan currently under review by government planners includes provisions that enable parents to pay for childcare with pretax dollars. This scheme includes a phased-in return to work for new parents and six-month unpaid parental leave with job protection. Home workers would enjoy full benefits including job security and hope of advancement could be guaranteed.

ALTERNATIVE WORK ARRANGEMENTS

Some parents need work arrangements that better balance family and work responsibilities. Others are part of the 15% (and rapidly growing) of the workforce that is part-time. They ask for flex-place and job sharing, flex-time and compressed work schedules, for home-work with full benefits and flexible relocation policy alternatives. While these concepts are mouthfuls and still not part of management lexicon, they are gaining credibility among workplace change advocates.

Work Well, a company based in B.C., issues a periodical dealing with case studies of options at work. Its director, Bruce O'Hara, notes that over the last five years, many employers have included flexible working hours as part of their employment package. Flexible hours can be used to reduce the number of hours a child is placed in daycare. Organizations like O'Hara's provide information on alternative work arrangements to individuals, unions, and employers.

A survey undertaken by Metro Toronto's Social Planning Council in 1985 determined that alternative work experiments were not unusual in that city. Researchers there found corporate policies that allowed for reduced or flexible work hours (25% of the 500 firms surveyed), part-time work with prorated benefits (20%), and short-term paid leave for family-related responsibilities. At that time, only 5.7% of workplaces had job sharing. Fewer than 10% of employers had three or more such arrangements.

The obstacles to acceptance of such ideas are formidable. Nonetheless, there are reasons for agreeing that work/family issues management is "the sleeping giant" of productivity improvement, especially for corporations that try to attract and retain skilled people. Those reasons are tied up in childcare-related topics such as staff turnover and retraining costs, recruitment, absenteeism, tardiness, and staff morale difficulties, as well as corporate image. Employers increasingly recognize that people don't leave their work problems at work nor their home problems at home.

CREATING A DESIRABLE FUTURE

Is any one option inherently superior? And how does an employer choose? "A longer term, structured and systemic approach is perhaps the best way to proceed," says Richard Bradley, a civil servant responsible for such programs in Ontario. Employers are advised to examine options from a number of perspectives, including corporate philosophy, integration with existing human relations and employee benefits policies, and employee need.

Experimentation is increasingly common. At the Ontario Hospital Association, an absenteeism problem led to exploration of alternatives, including staff information, a recreation program, plans for a childcare centre, and flex-time initiatives. At Manpower Temporary, a counselling service and home-work option satisfy numerous corporate goals, including a competitive edge in securing competent workers. George Brown College administrators search for sites like the Queen Street Mental Health Centre and the Mount Sinai Hospital at which they offer to operate daycare centres in return for providing training opportunities for their childcare students.

Dialogue and cooperation, notes Laurel Rothman, president of the Ontario Coalition for Better Childcare, are helpful. An example she gives is the Fashion District Daycare. Originally organized for parents

who work in the manufacturing end of the business (piecework sewing), it now serves various workers in that trade. The industry contributed start-up capital funds as a result of negotiations between the Fashion Advisory Committee and the Ladies Dress and Sportswear Industry. The site is one of three in Toronto where George Brown Community College students train on the job in return for the College picking up the centre's annual operating deficit.

THE ROLE OF GOVERNMENT

Over the past five years, two major federal task forces have issued childcare reports. Both the Task Force on Childcare, which reported in 1986, and the Special Committee on Childcare, with its final report in early 1987, recommended sweeping changes to the nation's childcare system over the next 10 years. Draft legislation currently before Parliament proposes a $6.4 billion program highlighted by tax credits, tri-level government cooperation, and a doubling of the number of new subsidized daycare spaces by 1994. Ottawa proposes to parcel out $4 billion of the total to the provinces to build new daycare centres and help existing ones meet their operating costs. While the debate and ensuing provincial programs have yet to happen, the current government seems committed to funding private commercial daycare and tax breaks for daycare.

Employers can approach the Ontario government for up to 80% of a daycare centre's projected capital costs as well as an initial operating grant. Most provinces contribute funds indirectly through a program of financial assistance to parents and directly through programs available to licensed childcare services providers.

Some employers want to wait until government legislation compels them to act on this issue. Others prefer to act rather than react. Still others see weaknesses in the federal bill. For example, there are no labor policy changes that would make work hours more flexible for parents who want to spend more time with their kids. As well, the level of expenditure falls short of the $11 billion universal national system advocated by activists like Maryanne DiIorio of the Ontario Coalition For Better Daycare.

THE REARGUARD OF THE VANGUARD

Karen Liberman suggests that many Canadian corporate managers share the philosophy of the executive who said: "I don't want to

be in the vanguard on this issue. I'd prefer to be in the vanguard of the rearguard." If this attitude is typical, then the issue is when and how—not whether—employers will act on childcare.

Corporate Canada may well be at that take-off or readiness stage today. Leading "follower-employers" want to be seen to be supporting the physical and mental well-being as well as home/work responsibilities of their employees, whether they work at home or at work. Elements in the organized labor movement are developing strategies on this issue. It becomes ever more common to see gaggles of tots walking along office corridors and city streets. We watch with interest to see how often it will be the silent hand of an employer helping to make quality universal childcare a reality in Canada.

RESOURCES

Books

Laura Johnson and Michael Yzerman, *Putting the Pieces Together* (Social Planning Council of Metropolitan Toronto: 1988)

Marjorie Martin, *Employer-Supported Child Care in Canada* (University of Victoria: 1985)

Stephen Lyndenberg, *Business Takes First Real Steps: Child Care Update* (Council on Economic Priorities: 1986)

Bruce O'Hara, *Put Work in Its Place* (Work Well: 1987)

Jane Beach and Laurel Rothman, *Study of Work-Related Daycare in Canada* (Status of Women: 1985)

Government Funding for Employer Initiatives

Richard Bradley, Ontario Ministry of Community and Social Services, Toronto (416) 965-3130

Nicole Marcotte, Office des services de garde à l'enfance, Montreal (514) 873-2323

Fran Pardee, B.C. Ministry of Social Services and Housing, Vancouver (604) 387-1275

RURAL WOMEN AND THE WORKPLACE

CHRISTINE BOIS

The characteristics of rural life play an important part in the lives and health of working rural women. The person-on-the-street impression of the working woman—often reflected in the media—has her dashing off to work on a bus after dropping her child off at daycare. She may slip away at lunch for a private appointment. After work, she joins her best friend for a drink before picking up deli food for dinner. This is an image that is more typical of an urban working woman than of a rural working woman.

The rural working woman does not start her day with public transportation. In fact, in winter, she may not even get out of her laneway until it has been "blown out." A daycare service may be available, but most likely children are left with a babysitter or a family member. At lunch time, slipping away for a private appointment is unlikely because the service may be 30 km away. The rural working woman, as a rule, does not end her working day in a bar, as rural attitudes are much more traditional than urban attitudes about women's drinking behavior.

BARRIERS TO HELP

"The country" conjures up a romantic image for the urban person. Although rural life has many advantages, in comparison to urban life there are important differences that impinge on the rural

woman. She faces barriers to obtaining help that are unique to the rural setting, and it is crucial that those who address the worksite health care needs of rural women know and understand the importance of these barriers in order to have an Employee Assistance Program (EAP) that truly serves all employees.

The four main barriers to rural women in obtaining appropriate services are: lack of the service itself; lack of means of transportation; isolation/lack of privacy; and traditional attitudes.

Let us consider each barrier separately. In describing these barriers, access to alcohol-related services in particular is used as the working example throughout the article. Although the barriers are described separately, they are interconnected as they affect a woman's life.

Lack of the Service

With regard to health and social services, most rural areas are undersupplied. The dearth of appropriate alcohol- and drug-related programs is a prime example. There may not be an appropriate service available; the existing service may be understaffed; or the program may have entry restrictions such as being "for males only" or will not accept drug problems other than alcohol abuse. Though there are some resources such as mental health centres or Family and Children's Services (with a mandate of child protection), the staff of these agencies are often overworked or have skills limited to their specific mandate. Appropriate specialists (for example, a therapist with family therapy skills) may not be available or may be too costly for many women. This lack of services also means that there is a limited range of referral options: for example, no female counsellor may be available; there may be very few Alcoholics Anonymous (AA) meetings in the area; there may be no women's AA group. Thus, choices usually do not exist, or are extremely limited.

Alcohol-related referrals to an urban centre may be possible but not necessarily satisfactory. A survey (Ireland, 1983) of rural farm women demonstrated that the least degree of satisfaction for their problem came from urban professionals, because urban professionals were not familiar with rural life and rural problems. Interestingly, the largest percentage of women in this study found the greatest degree of satisfaction and emotional support from their spouse and friends.

A local service may become inaccessible for a very particular rural reason: everyone knows everyone else. For example, if the local counsellor plays on your broomball team, you may have serious doubts about seeing him/her professionally, either because of embarrassment, the difficulty in admitting to a problem, or perhaps questions about his/her credibility. The reputation of a worker or a service is often widely known—for better or worse. Information and rumors travel fast on the rural grapevine and can naturally influence a person's decision, and degree of comfort, in using a given service provider or agency.

When an EAP counsellor is faced with referring a woman for help, there are a number of factors to be considered. Once the counsellor has established whether or not a service is available, it is important to clarify the appropriateness of the service, entry restrictions, and waiting time.

The quality of the care provided should be assessed, as well as the client's comfort with, and preference for, using that particular agency. When referral problems are encountered, alternatives need to be seriously considered. For example, there may be a more appropriate and accessible service in a nearby community. Is there a private practitioner who could provide the desired service? Could the employer pay for the service? Other program alternatives might also be considered: a ministerial association may have a minister or pastor with counselling skills; the extended family often lives in close proximity and members can provide supportive assistance. Obviously, creative thinking and inventiveness on the part of EAP personnel are needed to produce the resources to fit the needs of individual women.

Lack of Transportation

Lack of transportation is an extremely common barrier to obtaining help in rural communities. Without a public transportation system, women cannot access services easily. A recent community health survey (Harris, 1988) in a rural area found that 16% of females as compared to 5% of males did not drive; and women in the age group 18 to 34 reported most difficulty with transportation.

Linking a rural woman with appropriate help means ensuring that she has transportation to attend appointments. This may mean exploring with her alternative means of transportation, such as having a family member, a friend, or a co-worker drive her. Recruiting volunteer drivers and having a volunteer list available is also useful. In

addition, rural employers may provide their employees with transportation to appointments. Police and ambulance services are resources not to be overlooked in a medical and/or legal emergency.

It is important to be very specific about a woman's means of transportation. For instance, she may have a car that she uses locally but will not drive in the city. It is not uncommon for rural residents to dislike city driving.

Isolation/Lack of Privacy

Isolation and lack of privacy are two features of rural living that may seem to contradict one another but in fact do not. For example, a woman recovering from alcoholism may have no neighbors nearby, and may have no accessible or available support groups or not one with which she can readily identify. There may be one AA group, predominantly male. The work setting therefore becomes an important focal point for easing such rural isolation. At the same time, concern with lack of privacy may hinder a woman from discussing her situation with co-workers or worksite health care personnel.

Anonymity can be difficult to preserve in rural areas. One's private and family life may in fact not be very private. Confidentiality is a common issue about which clients are concerned. For instance, not only is it possible that one's lawyer's secretary is also one's neighbor, but also one's doctor's nurse may be a third cousin. Another common occurrence is to meet one's counsellor at the supermarket or on the street. These situations are often discussed and clearly demonstrate a concern among clients. The privacy issue may reduce a distressed woman's options. Thus, it is one that needs to be overcome by developing innovative alternatives. Such alternatives could include: discussions with the client about her concerns regarding confidentiality; keeping her file separate from the general files; setting appointments at "secure" times; developing guidelines regarding meeting her counsellor in public places.

Traditional Attitudes

Traditional attitudes about seeking help are still strong in rural areas. Managing your own problems and keeping them "in the family" is the prevailing norm. This attitude appears to have its most profound effect on men and may present real difficulty for a woman who chooses to involve her spouse/partner in counselling. In this process enlisting

the assistance of a physican can be useful. A physician's referral is more likely to be acceptable and to be heeded.

A more difficult attitude to deal with is the denial of a woman's drinking problem. Denial of drinking problems in women is common in all settings, but in rural areas it may often be much stronger, particularly by the woman herself. This denial hides the problem longer—often exacerbating it—and can contribute to lowered self-esteem. Thoughtful counselling often needs to be conducted before a rural woman feels comfortable discussing her drinking behavior or accepting a referral to a community service or program. However, an unwillingness to attend the local AA meeting may not be denial but rather concern about lack of anonymity.

SUMMARY

EAP personnel working with women living in a rural setting must be sensitive to rural issues, circumstances, and values. Most important, they need to be skilled in their assessment and referral planning in order to ensure that barriers to help have been overcome. They may have to take a much more active role in assisting the rural woman in obtaining needed service than might be required in the urban context.

The design, implementation, and administration of a progressive EAP for rural women has to take into account not only issues particular to women but also issues particular to the rural setting in which they live. Both employer and unions must strive for an EAP that is comprehensive and flexible. Such an accommodating program in rural areas may require the inclusion of such features as on-site counselling, worksite support groups, provision of transportation to health and social services, and extended health care coverage.

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WOMEN, UNIONS, AND WORKSITE HEALTH

LINDA WILCOTT

HISTORICAL BACKGROUND

With the advent of women entering the paid workforce at the turn of the century, many varied opinions emerged as to what was best for the "working girl."

> Since women were defined as the bearers of the moral standard of the nation, their entry into a workforce dominated by an amoral male ethic that subjected them to temptation and distracted them from their true calling of motherhood was indeed a critical aspect of the social crisis. (Klein & Roberts, 1974).

Any interventions to improve working conditions, made on behalf of these working women by the reformers of the day, were put forward with the patronizing attitude of wanting to protect the purity and modesty of these vulnerable future mothers. Their intent was to safeguard the moral fibre of society, and not to improve the conditions and organization of work and its impact on women workers.

As more and more women entered the workforce over the next two decades (1900-1920), the liberal upper- and middle-class reformers' voices were increasingly being challenged by the voices of working women themselves. Trade unions and suffragettes also now entered the picture.

Male-dominated unions of this era did not become instant allies of working women. The unions supported the existing and traditional view of women as only mothers and homemakers. "Yet often the logic of their own interests pressed them to take a progressive stance on key issues of civil and industrial rights, thus causing considerable internal tension and ambivalence in their overall view of women workers" (Klein & Roberts, 1974).

Although government factory inspectors of the day concerned themselves with the health and safety of women workers, the issues of wages and hours did not gain attention until women organized into unions and went on strike over those very issues. Involving mostly female employees, the Bell Telephone strike of 1907 highlighted the long hours worked as well as the matter of night shifts.

Women workers gained equal pay for equal work only because union men feared that the entry of women in the workforce would lower their wages. Thus the solution was seen as equalizing wages for both sexes doing like work (Klein & Roberts, 1974).

The end of the Great Depression and the onset of the Second World War marked a dramatic increase in the number of women in the workforce. More women became leaders in the labor movement during this time. Increased participation during the post-war years was paralleled by an increased awareness of the problems faced by women. "Equal pay for equal work" helped to end some of the most blatant forms of discrimination but said nothing about job ghettos and lack of opportunity for women.

In 1956, the Trades and Labour Congress and the Canadian Congress of Labour merged to form the present Canadian Labour Congress (CLC). Issues of concern to women had very low priority for the first 10 years of the new organization's existence. At that time, 16.4% (1962 figures) of workers in the 117 affiliated unions were women (Statistics Canada, 1971). By comparison, in 1985 36.2% of organized workers were women (Statistics Canada, 1985). This increase can be partially explained by a new initiative begun in 1966, when the Human Rights Committee of the CLC called for an end to discrimination against women through collective bargaining and effective legislation.

In 1967, a committee of the CLC prepared a brief to the Royal Commission on the Status of Women. The brief looked into some of the real problem areas of discrimination: equal pay; access to education and training; income tax; childcare; and "protective legislation."

At a 1972 convention, the CLC executive was directed by the membership to draw up a program of action to encourage unions to assist in the improvement of the status of women. A special report on the rights of women was put together for the following 1974 CLC convention.

In 1976, a subcommittee of the CLC Human Rights Committee dealing with women's rights held a national conference on women's issues. At the conference, a statement, "Equality of Opportunity and Treatment for Women Workers," was drawn up, based upon the standards of the International Labour Organization. This statement was accepted by the 1976 CLC convention and became the cornerstone for future policy development. One of its recommendations was to establish a "Department on the Status of Women Workers" (Canadian Labour Congress, 1976) and in December 1977 the CLC Women's Bureau was formed. The CLC now has a Women's Committee.

Individually and collectively, women continue to gain recognition in the labor movement. Yet, the problems women faced at the turn of the century still exist, albeit in different forms and to varying degrees. The following sections will now expand upon some of those issues as they are understood today, and will put forward organized labor's response on key issues: health and safety, sexual harassment, childcare, and equality.

HEALTH AND SAFETY

In 1987, women comprised 43.4% of Canada's total workforce (Statistics Canada, 1988), and 56% of all mothers with children under the age of 3 were in the workforce. In this same year, only 31.9% of paid women workers were unionized (Labour Canada, 1986), and the average earnings of full-time women workers were only 66% of average earnings of full-time men workers (Statistics Canada, 1977, 1987).

As a rule, women shoulder a double workload. Besides having a job in the paid labor force, they are still expected to perform most of society's childcare and other family service work. Lack of unionization of women workers generally means lower wages and poorer benefits. Since 86% of single-parent families are headed by females (Statistics Canada, 1985), parenting responsibilities are often made heavier by low income.

The resulting stress can lead to illness, fatigue, anxiety, and alcohol or drug abuse and dependency, which can in turn lead to

workplace accidents among other problems. Such demands on a woman's time and energy also discourage her from becoming active in her union, or even more to organize a union to try to bring about improvements in working conditions.

Lack of union protection often means the endurance of unhealthy and unsafe working conditions. A CLC pamphlet entitled *Women and Health and Safety* explains the following hazards and symptoms faced by working women. Stress is common among workers limited to performing monotonous low-paid work with few prospects for training, promotion, or control over their jobs. Women who do piecework, or who are working with technology that allows employers to monitor individual productivity, are subject to pressure that can lead to accidents. Stress from these factors, from overwork or shift work, from production pressures, or from physical hazards can cause mental illness and physical symptoms. Psychological stress also makes workers more susceptible to other health hazards.

Noise, vibration, extremes of temperature, and poor lighting cause accidents and disease. Textile workers and typists can suffer hearing loss from the noisy machinery they utilize. Laundry workers and dry cleaners risk heart strain and heat exhaustion. Glare from shiny work surfaces or video display screens causes eyestrain and fatigue. Typists, clerks, telephone operators, and component workers all have jobs that require small, repetitious movements of the fingers, wrists, elbows, or ankles. Such movements done over and over again at high speed can cause painful inflammation of the tendons and eventual permanent crippling. Most of the jobs that cause this kind of injury are performed by women (Canadian Labour Congress, n.d.).

The harmful results of exposure to chemicals or radiation may not show up in the worker or her children until 10 to 20 years later. Hospital and dental workers are exposed to radiation and anesthetic gases that can cause genetic damage or miscarriage. Health care workers, textile workers, cleaners, laundry workers, and office workers are in constant contact with dangerous chemicals causing diseases from skin rashes to cancer. People working with plants or animals face biological hazards. Health care workers, teachers, and childcare workers are at risk of contacting contagious diseases.

There is evidence that exposure to radiation (low-level or other) and to chemical substances can harm reproductive health (Miller-Chenier, 1982). In the past the emphasis of research on reproductive

hazards has been on the fetus. As a result, workplace policies have excluded women of childbearing age from hazardous jobs in order to protect the fetus. However, if workplace hazards can damage female reproductive health or the fetus, then one might suspect that these hazards are also dangerous to the health and reproductive health of male workers. In short, the exclusion of women from such a workplace does not eliminate the hazards. Moreover, excluding fertile or pregnant women from certain jobs can be interpreted as discrimination on the basis of sex according to some human rights legislation.

Different health and safety standards (e.g., reproductive protection standards) for women and men protect corporate profits in that they substitute for costly changes to the work environment. The solution is to clean up the workplace, not to deny women workers employment or leave men workers to face the hazards.

Better health and safety laws are crucial for all workers, especially for women who work without union protection. All workers need safe workplaces, guaranteed access to information regarding hazards, and the right to refuse dangerous work.

The CLC recommends that union women become more involved in health and safety issues, through local union women's committees, health and safety committees, and collective bargaining committees. Collective bargaining is a means of protecting workers from reproductive and other workplace hazards.

Strong health and safety clauses in a collective agreement can include: joint health and safety committees; the right to refuse unsafe or unhealthy work; access to information on all materials used or produced in the workplace; transfers, without loss of pay, seniority, or benefits, for pregnant women or for men and women planning to conceive; and paid disability leave if transfer is not possible.

The best laws only guarantee a minimum of protection. A strong collective agreement offers the best protection.

SEXUAL HARASSMENT

The most common and least discussed occupational health hazard for women is sexual harassment. At least once in their working lives, most women will be victims of unwelcome advances on the job. Sexual harassment is shared by every job level and every occupation.

Sexual harassment places women under severe emotional stress that can cause psychological problems such as depression or physical

symptoms such as insomnia, headaches, or stomach upsets. Many women who refuse sexual advances on the job pay the price professionally in lost job opportunities or lost promotions. Many women just quit their jobs to escape harassment.

Protection under existing legislation (criminal law, human rights commissions) is unsatisfactory in that it is selective, differs from region to region, and takes a long time and money to get results. The ideal remedy is for women to go through the union. Women workers should document and report all cases of sexual harassment to their union. By reporting all cases and discussing the problem at union meetings, the importance of putting protective language in the next collective agreement (if not already included) will be more readily apparent.

Many women have found that they have greater success in grieving their concerns in groups rather than as individuals, and unions can help women launch group action. Unions can support women who have been victims of sexual harassment by helping them seek remedies through human rights commissions or by providing legal counsel. Through their unions, women workers can lobby for change in legislation, do research to uncover the extent of the problem in the workplace, and be a necessary support for victims of sexual harassment.

CHILDCARE

Daily, thousands of parents step out of their homes to go to work. Some are forced to leave their children in inadequate, expensive, unstimulating, or unsafe childcare arrangements. The personal worry faced by these parents is a symptom of Canada's growing crisis in childcare.

Single-parent families, economic pressures on the nuclear family, and the need of women for personal fulfilment have meant increasing numbers of mothers in the workplace. Each family has to cope individually with the problems of finding childcare.

The problems faced by women seeking childcare services are "prohibitive fees, demeaning needs or income tests, long waiting lists, inconsistent quality of care" (Canadian Labour Congress, 1986, p.2). For childcare workers themselves, who are most often women, "the present system means poverty level wages and inferior working conditions" (Canadian Labour Congress, 1986, p.2). Another set of related problems facing working women and men is that of parental rights. Most employees are not given paid leave of absence to fulfil parental responsibilities

such as looking after a sick child or attending a meeting with a teacher at school.

Women are still usually the ones who are responsible for household work and family responsibilities when they return home from their jobs. Research shows that not many men take on added responsibility for household tasks and childcare when their partners are in the paid workforce. According to one study, husbands in childless marriages increased their housework time by six minutes a day when their wives joined the workforce. In families with children, husbands contributed one additional hour of housework (Armstrong & Armstrong, 1978).

Many women do not have any support systems and feel isolated because their employment has created a crisis in the way work is distributed among family members; these women may perceive their problems as personal and unique to their own marriages rather than part of a large-scale problem of reconciling work and family life (Luxton, 1980).

Thus, lack of adequate childcare, lack of parental rights at work, and the double burden of working and parenting create additional worries and stress. This stress can affect not only a woman's job performance but also her personal relationships at home. If she works in a noisy or hazardous workplace, the result could be overwhelming.

The CLC is pressing the federal government to develop a national childcare system that would provide universal access, be non-profit (government funded), be comprehensive in nature (preschool and before/after-school services), and be of high quality.

The CLC also calls upon the federal government to enshrine parental rights in legislation, as a complement to the provision of childcare facilities.

Women's progress toward equality must include increased emphasis on the sharing of domestic labor. Although no policy or program can guarantee that sharing will happen, unions can work to include in their collective agreements such items as paid parental leave, family responsibility leave, and other measures that are needed to encourage shared parenting and shared domestic labor, such as shorter working time with no loss in pay.

The CLC and some of its affiliated unions now provide childcare at their conventions and conferences. Many local unions now accept childcare costs as a legitimate expense for members doing union business.

The Canadian labor movement has been proactive in seeking social change to address the inequalities and injustices faced by working women. Some of these issues, other than those mentioned earlier in this article, include affirmative action, equal pay for work of equal value, job security, pensions, paid maternity benefits, and technological change.

UNION COUNSELLING PROGRAMS AND JOINT EMPLOYEE ASSISTANCE PROGRAMS

Worker-help programs such as the CLC Union Counselling Program (UCP) and Joint Employee Assistance Programs (Joint EAPs) can address the problems faced by working women that are not covered by the collective agreement.

The UCP is operated fully by the union with or without recognition and resource assistance from the employer. The Joint EAP is operated by a joint committee with equal representation from both the union and the employer. The CLC has guidelines for both types of programs available to its members. Traditionally, worker-help programs focused solely on problems of alcohol, and subsequently drug abuse or dependency. Modern programs are now "broad-brush" in that all types of problems of personal impact are dealt with (e.g., marital; financial; general information; housing; childcare; strikes and layoffs; depression; suicide attempts; wife-battering; child or elder abuse). Most worker-help program services are extended to workers' families and even sometimes to retirees.

As outlined in this article the problems and conditions faced by working women in the workplace and at home can place great stress on them. Stress for a short period of time can be endured and may even be positive. However, continual stress of any great degree will take its toll. Such stress can manifest itself in such forms as disease, psychological or emotional problems, or alcoholism and drug dependency.

The UCP or Joint EAP referral agent can link up the woman worker with the appropriate community social service to look after her immediate and personal needs, and at the same time work cooperatively with the union to deal with the conditions or organization of work that may have contributed to her problem. In this way the root cause of a problem can be dealt with to prevent other workers having to suffer the same fate.

Needless to say, confidentiality is the key to the success of these programs.

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HEALTH ISSUES

THE HEALTH OF FEMALE WORKERS: Worksite Programming Implications

CHARLES PONÉE

Over the past three decades in North America, worker health has become a prime focus of action for governments at all levels and for management and labor at the worksite. Progressive health and safety legislation and related worksite programming have been the result (Herzlinger, Schwartz, & Calkins, 1985/86). However, there is both need and room for continued progressive change in this domain (Warner et al., 1988).

It is clearly evident that since the Second World War, the North American workforce has undergone, and continues to undergo, a dramatic set of changes, many of which generate stress-related health problems for workers. Women now form the majority of workers in the Canadian labor force and a very major portion in the United States. A woman at the worksite is now more likely to be married than she once was and is more likely to be a mother. These facts hold considerable impact for our society, for the worksite, and more fundamentally for the health and well-being of the female worker herself; for, as scientific observation indicates, work, its organization, and the fear of its loss are major causes of injury and illness (Kiefhaber & Goldbeck, 1983). Also, it is clearly established that, as with men, mortality and morbidity are class-related for women, with women at low income levels exhibiting higher rates of mortality and morbidity than higher-income women.

Poor women manifest high rates of acute and chronic conditions and mental disorders (Rosenbaum, 1986). Clearly, there are many important reasons for concerns about the health of working women (McDaniel, 1987). But what do we currently know about the health risks of working-age women and what implications do these hold for employers?

GENERAL HEALTH RISKS

The scientific literature on the health and health risks of Canadians and Americans is astoundingly clear. There are six key lifestyle-related factors that are directly associated with those diseases/illnesses that cause approximately 80% of all North American deaths, many of which are premature. These factors are: smoking, high blood cholesterol, high blood pressure, obesity, alcohol abuse, and physical inactivity (Herzlinger, Schwartz, & Calkins, 1986).

In 1984, the National Center for Health Statistics attempted to determine the percentage of total deaths represented by each of the ten leading causes of death in the United States in 1983, and identify associated risk factors. This profile is reflected in Table 1.

As men and women have more biology in common than not, the majority of physical health disorders resulting from these lifestyle factors are found in both men and women (Alexander, 1987).

However, there are a number of health problems that predominate among men. For example, men have three times as many heart attacks as women (heart attacks account for approximately 30% of all male deaths), and two-thirds of alcoholics are male. Conversely, there are health problems of special significance and concern to women.

WOMEN'S HEALTH PROBLEMS

Although there are very few health problems entirely unique to either sex, there are a number of disorders that: (1) occur more frequently or exclusively in women; (2) present differently in women; and/or (3) demand "female specific" treatment responses (Alexander, 1987). Outlined below, and generally presented according to prevalence, are those key health disorders that are, for the reasons noted, relevant to working-age women. It is hoped that this overview will serve to sensitize key worksite influencers to the wide array of health concerns of working women. As health promotion specialists will attest, it is only by knowing the health needs, risks, and preferences of such a group of employees that one can begin to develop effective worksite health promotion initiatives.

TABLE 1

PERCENTAGE OF TOTAL DEATHS AND RISK FACTORS FOR TEN LEADING CAUSES OF DEATH IN THE UNITED STATES IN 1983

Cause of death	% *of total deaths*	*Risk factors*
Heart disease	38.1	Smoking, hypertension, hypercholesterolemia, lack of exercise, diabetes mellitus, obesity, stress
Cancer	21.9	Smoking, alcohol, diet, environmental carcinogens, obesity
Stroke	7.8	Hypertension, smoking, hypercholesterolemia, stress
Accidents	4.5	Alcohol, failure to use seatbelts
Chronic obstructive lung disease	3.3	Smoking
Pneumonia and influenza	2.7	Smoking, alcohol
Diabetes mellitus	1.8	Obesity
Suicide	1.4	Stress, alcohol, drug use
Cirrhosis	1.4	Alcohol
Arteriosclerosis	1.3	Smoking, hypercholesterolemia
Other	15.7	
All causes	100.0	

Source: National Center for Health Statistics, 1984.

CARDIOVASCULAR DISEASES

> Atherosclerosis is literally "hardening of the arteries"; it is an inexact term which embraces all pathological processes associated with thickening and loss of elasticity of arterial walls, the commonest being arteriosclerosis. (Walton, 1986)

Hypertension is "persistently high arterial blood pressure" (Walton, 1986). Atherosclerosis and hypertension are generally considered the cardiovascular diseases that most commonly affect women, especially in later years (Dustan, 1987). Although atherosclerosis is more common in men than women, it does affect women, although 10 to 15 years later in life. Hypertension appears about equally in both sexes, primarily in middle-aged and older persons.

These diseases cause considerable disability and death. Atherosclerosis can result in myocardial infarction (the terms "coronary thrombosis," "myocardial infarction," and "heart attack" are virtually synonymous), thrombosis (intravascular blood coagulation), stroke (a sudden impairment of brain function due to hemorrhage from or obstruction of one or more cerebral blood vessels: Walton, 1986), and intermittent claudication (pain in the calves on walking). Hypertension can damage small blood vessels, causing kidney failure, hemorrhagic strokes, and heart failure. Hypertension is also an important factor in atherosclerosis.

According to a 1985 National Institute of Health report, heart disease now leads all other causes of death in women. Slightly less than half (250,000) of all Americans who die of heart disease are women.

Nutrition is of primary importance to both diseases. Atherosclerosis is affected by obesity, high salt intake, excessive alcohol use, and smoking. Excessive alcohol intake has recently been identified as a risk factor for hypertension (Dustan, 1987).

CANCER

Cancer, a disease characterized by the uncontrolled new growth of cells that exhibit properties of invasiveness and remote spread, is a major health threat to women. In fact, it is the second greatest cause of death among women. Those women in the 35-to-54 age bracket are at particular risk. Although women experience a broad range of cancers, three of the most common cancers—lung, breast, and cervical cancer—are of special importance.

Other cancers of special concern to women, though not of the

same degree of prevalence, are those of the ovaries, endometrium (uterus lining), and colon; 52,000 women are diagnosed with colon cancer each year in the U.S., and 27,000 die from it annually (Henney, 1987).

Lung Cancer

Lung cancer, specifically related to the increase in the use of tobacco by women, especially young women, is a major cause of death among all cancers. The American scenario, as one example, is rather overpowering. In the United States, between 1950 and 1985, lung cancer deaths in women increased a full 500% (Itri, 1987). In 1986, 49,000 American women were diagnosed as having lung cancer. Only 16% of them are likely to survive five years or more. The Canadian picture appears no less pessimistic. To complicate matters further, smoking also poses a special risk of coronary heart disease in women, especially when used in tandem with oral contraceptives. In addition, smoking tobacco during pregnancy (or marijuana, for that matter) carries special risks for both mother and unborn child. (Recent evidence indicates that chronic exposure to second-hand smoke contributes to risk.) Finally, the incidence of pulmonary emphysema (a lung disorder) has risen sharply among women in recent years. Here smoking has been identified as the activating agent.

If a woman who smokes chooses to improve her health, and wants to increase her chances of avoiding lung cancer, the most constructive thing she can do is quit smoking.

Breast Cancer

In degree of health impact, breast cancer follows very closely on the heels of lung cancer as the second major cancer threat to women. Although found in some men, breast cancer is primarily a women's illness affecting one in 12. Those factors—some lifestyle related— that appear to correlate with breast cancer are aging, fatty diet, calorie intake, and height and weight (Lippman, 1987).

The treatment of breast cancer has improved, and as a result, mortality has been reduced. Health promotion through nutrition and early detection through regular medical check-ups (especially for women from high-risk families, as genetics appears to be a determinant), mammography (radiographic examination of the breast), and self-administered breast examination are key to reducing risk.

Cervical Cancer

One cancer prominent in the news is cervical carcinoma. Overwhelming evidence indicates that human papilloma virus (HPV)—genital warts in the woman and/or her sexual partner—is implicated in this type of cancer. According to Michael J. Champion, Research Director of the Regional Cancer Center, Atlanta, about two-thirds of women under age 35 are infected with this sexually transmitted pathogen and whites are somewhat more susceptible than blacks. If a woman has vulvar warts, she has a one-in-three chance of having cervical precancer.

REPRODUCTION

Reproduction, a personal matter, yet an issue of considerable political attention at the moment, has, despite its attendant joys, been the cause of enormous suffering and death among women (Steinem, 1983). Those areas of health concern for women related to reproduction include infertility, unplanned pregnancies, contraception, the menstrual cycle, and menopause.

Science has made major advances in pregnancy-related matters. Improvements in lifestyle and health care such as the control of infection and hemorrhage, the timing and spacing of pregnancies, and a shift to safer childbearing ages have all contributed to healthier mothers and infants. One recent phenomenon is that of late pregnancy: more and more women are beginning families at later ages than was once the norm.

The mortality rate of babies has dropped considerably in recent decades. Today, in Canada for example, 98% of newborn babies reach adulthood. In addition, fertility has dropped more than 50% since 1959. In 1961 the average Canadian household size was four persons; today it is about 2.3 persons (Health and Welfare Canada, 1987).

In spite of decreased infant mortality and a reduced fertility rate, serious issues remain. It is estimated that half of all pregnancies are unplanned. Most such pregnancies occur among young women. Effective means of contraception are available; however, better-informed consumers, both male and female, are required.

Premenstrual Syndrome (PMS)

Premenstrual Syndrome (PMS) is characterized by a cyclic occurrence of symptoms of varying severity and is related to menstruation, with a

heightening of symptoms during the luteal (premenstrual) phase. (Vaitukaitis, 1987)

The normal menstruation cycle involves a delicate concert of events characterized by mid-cycle ovulation and, if no pregnancy is achieved, menstrual flow. Painful menstruation (dysmenorrhea) and normal complaints related to menstruation are often a focus of worksite health care providers when working with large numbers of female employees.

In some women there is a worsening of mood until the onset of menses, then a sudden, dramatic lessening of symptoms, and a gradual build-up of symptoms again. Some two hundred symptoms have been labelled premenstrual syndrome (Woods Fugate, 1987). It appears that, in reality, there is a low prevalence of premenstrual syndrome. Peak symptom severity is usually at menses rather than premenses.

Menopause

Another reproduction-related concern for women is menopause (the permanent cessation of menstruation, usually occurring between the ages of 45 and 50) and its associated symptoms. These symptoms, which may include memory lapses, anxiety, depression, and hot flashes among others—and can vary considerably from person to person in both number, extent, and intensity—may have a negative impact upon performance and productivity. Further, the occurrence of menopause tends to coincide with other life events such as the peaking or plateauing of careers, the emergence of responsibilities for the care of aging parents, and the departure of grown children from the home. Stress related to these events can exacerbate the situation.

Worksite leaders, management and labor alike, must be aware of menopause-related health concerns in their older female employees and ensure that support and assistance are available to them.

Sexually Transmitted Diseases

Sexually transmitted diseases have been, and continue to be, a major and growing health problem for men and women alike. The workplace provides an ideal focal point for employee education regarding sex practices and sexually transmitted diseases.

The sexually transmitted disease most common among young people (10% to 20%) is chlamydia. It should be noted as a cause of pelvic inflammatory disease and infertility.

Acquired Immune Deficiency Syndrome (AIDS)

> AIDS is caused by a virus called HIV (Human Immuno-Deficiency Virus) which attacks and seriously disrupts the body's immune system, its defence against disease. Without the protection of the immune system, people with AIDS suffer from fatal infections and cancers. (Health and Welfare Canada, 1988)

AIDS, a recently recognized syndrome, is rapidly becoming a serious health risk to men and to a lesser extent women. As of 1988 in the U.S., 1.5 million persons were infected by the AIDS virus (Darling & Lonnquist, 1988). Women are now facing this major health risk. Currently in New York, to use the most pronounced example, AIDS is the leading cause of death in women 25 to 29 years of age. Currently 7% of all known AIDS cases are women; in 1987, one-fifth of all new cases discovered in the United States were women. This fact reflects the growing heterosexual transmission of the AIDS virus to women from partners who are bisexual, as well as the transmission associated with the sharing of needles by intravenous drug users.

In Canada, up to October 1988, 2,040 cases of AIDS were identified, 52 of whom were women. In the province of Ontario to this time, 99% of cases were men (Caplan, 1988).

Medical treatments and vaccines for AIDS are still at an early stage of research. In the meantime, education for all is the most effective weapon against AIDS.

The workplace is being stressed as a key contact point for initiatives directed at the prevention and management of AIDS (Stotz & Steiner, 1988). Already, some creative health promotion measures have been introduced in progressive organizations (Halcrow, 1986). Also, excellent up-to-date AIDS information is readily available from the Federal Centre for AIDS (Ottawa) and the Ontario Ministry of Health.

DIABETES

> Diabetes Mellitus, or Diabetes, is a condition where the body cannot use sugar (glucose) properly. Sugar builds up in the blood. Some of this sugar is wasted as it passes from the body in large volumes of urine. The result is an energy shortage in body cells. (Canadian Diabetes Association, 1987)

Approximately 13 million Americans and 1 million Canadians have diabetes (Canadian Diabetes Association,1987; Kilo & Williamson,

1987). These people have trouble moving sugar out of the blood into the cells. Sometimes they do not make enough insulin (Type I Diabetes); more often, the insulin does not work properly (Type II Diabetes). Diabetes is diagnosed when too much sugar is found in the blood or urine.

Diabetes is thought to have genetic and environmental roots. Some indicators of risk are: weight; a family history of diabetes; age over 45; mother of a large baby; history of pancreatic disease or other condition predisposing to diabetes; and stress related to emotional upset, accident, illness, pregnancy, or surgery.

At present there is no cure for diabetes. However, once diagnosed, control is achieved by means of a treatment package that can include diet modification, exercise, medication (i.e., insulin), weight control, and lifestyle adjustments.

Diabetes for women poses a special concern in that, when it is not properly controlled, the unborn child's proper development may be endangered. The danger seems to arise from repeated high blood sugar levels and persistent ketones that are associated with poor diabetes control. Informed diabetes management is the key to the protection of the unborn child. Also, there is a form of diabetes, gestational diabetes, that develops during pregnancy (Canadian Diabetes Association, 1985).

It should be noted that diabetics may develop health problems earlier in life than non-diabetics. Circulatory and nerve disorders, an increased risk of infection, and injuries that do not heal well (e.g., foot problems) are major concerns. It is estimated that about 5% of North Americans can expect to develop diabetes at some stage in life.

THYROID CONDITION

The thyroid is the important endocrine gland situated in the front of the neck which controls the overall rate of the body's metabolism (Walton, 1986).

Thyroid problems appear in women at four to five times the rate in men. Overactivity of this gland can cause weight loss, heat intolerance and sweating, emotional lability and nervousness, tremor, and tachycardia. The factors contributing to this condition are unclear, although autoimmunity and genetics appear to play a part. However, treatment, which consists primarily of the use of medication and sometimes surgery, is usually curative.

PAIN

Although information on this subject is difficult to acquire, it appears that most women report experiencing more pain than men and that working mothers report significantly more pain than their home counterparts. There appears to be a link between stress and a general sense of unwellness. Crying at the workplace, considered one common expression of stress relief, appears to be a concern related especially to women workers (Frank, 1987).

Of interest, women report twice as many headaches as men, and women are believed to comprise three-quarters of all sufferers.

Back pain is an ailment that affects men and women, but significantly more women. It was recently reported that in North America 20 million people suffer with back pain and in Canada there are approximately 250,000 women and 25,000 men with back problems (Scanlon, 1986). In 1984 such problems accounted for one-quarter of all compensation claims in Canada. In that same year in the province of Ontario, the Ontario Workers' Compensation Board awarded $399 million for work-related back injuries. These injuries caused workers to lose about 3.1 million work days (Finlayson & Silburt, 1986).

ARTHRITIS

Arthritis, or the inflammation of a joint, which presents itself in many forms, is likely the most common chronic disease in North America. Left untreated it can be a very serious problem.

Arthritis, which afflicts more than 3.5 million Canadians—one person in seven—costs the country nearly $2 billion a year in direct costs alone. Of these Canadians, 1.5 million are in the workforce.

This disease describes more than 115 rheumatic conditions such as rheumatoid arthritis, osteoarthritis, and gout. Early diagnosis and wise management are the keys to treatment, although there is at this point no cure (Arthritis Society, 1983).

SYSTEMIC LUPUS ERYTHEMATOSUS

> A disease of unknown causation and variable manifestations, ranging from a skin disorder to a generalized disorder involving the skin and viscera. (Osol, 1972)

This disease claims women as 90% of its victims. In earlier times the death rate for this ailment was high. Today, although there is no known cure, treatment—medication, heat or cold treatments, exercises,

rest, joint protection, and avoiding sun exposure—helps to manage the disease.

OSTEOPOROSIS

> Deossification with absolute decrease in bone tissue, resulting in enlargement of marrow and haversian spaces, decreased thickness of cortex and trabeculae, and structural weakness. (Osol, 1972)

Osteoporosis is a disease in which the bones become porous and more susceptible to fracture. The areas most affected are the pelvis, the vertebrae, and the ends of long bones. Bone loss occurs most rapidly in white women following menopause (Steinberg, 1987). Currently the disease affects some 20 million Americans—mainly older women—and in Canada, 250,000 women and 25,000 men (Norris, 1987; Scanlon, 1986).

Estrogen deficiency, aging, smoking, high alcohol intake, high caffeine intake, high protein intake, and lean body mass are those factors that relate to the disease's presence. Also, certain diseases, operations, and drugs may be associated with the development of this illness (Rivlin, 1987).

Osteoporosis is an older woman's disease. Nutrition appears to hold some potential for its prevention and treatment. It is usually treated with calcium, vitamin D, and post-menopausal estrogen replacement. Exercise is also a recommended adjunct to treatment.

GALLSTONES

> A concentration formed in the gallbladder or the biliary ducts, composed, in varying amounts, of cholesterol, bilirubin, and other elements found in bile. (Osol, 1972)

The commonest variety of gallstone is composed mostly of cholesterol. The primary cause of gallstones, as of thyroid problems, is as yet not clearly understood. Gallstones may be symptomless or may give rise to abdominal pain, indigestion, and obstructive jaundice.

Gallstones appear in women four times more frequently than in men. Drugs and surgery have been the traditional treatment modalities.

OTHER HEALTH CONCERNS

A 1985 study of mental health problems by the National Institute of Mental Health found that, for women of all ages, phobias were the most frequent problem. Drug abuse by younger women, depression, and alcohol dependence were, in sequence, the most common problems

identified. Therefore, a number of other health disorders, although they may affect fewer women and/or initially appear as less life threatening, should be highlighted.

Depression

Depression, a very common illness among women, must be taken into account by worksite health care personnel as it holds major implications for performance. For example, depression in women (as in men) gets reflected in low energy, lack of interest, lack of motivation, and poor concentration, all of which affect work.

Mortality figures indicate that in Canada, for example, suicide is the fourth major cause of death among Canadians in their productive years. Suicide is an increasing phenomenon, among young people in particular. It is often linked to mental depression, which occurs twice as often in women as men. Therefore, suicide or attempted suicide among women, especially young women, is a major concern.

Phobias

It is a generally held view that one in every 12 employees experiences, at one time or another, anxiety and attacks of panic leading to phobias. Often such employees are super-achievers with very high expectations for their personal performance. The fear of venturing into "people places" (agoraphobia) is the most common phobia. Such problems surface among women more frequently than among men.

With 10 to 15 million sufferers in the United States alone, phobias have considerable impact upon the workplace. Fortunately, treatment, which consists mainly of medication and behavior modification counselling, is effective (Ingram & Wilson, 1987).

Alcohol Abuse

In the United States 3.5 million women abuse alcohol (Chatham, 1987). In Canada the figure is in the 200,000 range (Adrian, 1984). It is known that abuse of alcohol, often associated in women with depression and a feeling of "powerlessness," can have a negative effect on organs and body systems. Alcoholic women die 15 years earlier than non-alcoholic women and have death rates 50% to 100% higher than alcoholic men (Chatham, 1987). Women alcoholics start drinking and begin their pathological drinking patterns later than men, but they come into treatment at the same age and with about the same problem severity (Blume, 1986).

In addition, alcohol can have an effect upon hormonal functioning and on an unborn child. Fetal Alcohol Syndrome (FAS) occurs in one to three of every 1,000 births. FAS is now considered one of the three main causes of birth defects associated with mental retardation, and a completely preventable cause (Blume, 1987).

Today, it is being generally recognized that women who work outside the home, and concurrently carry a range of familial responsibilities as well, are under unique stresses (Hennessey, 1983) and are at special risk of becoming alcohol abusers (Pape, 1988).

Drug Abuse

The abuse—and sometimes the use—of mood-altering drugs other than alcohol and tobacco is another problem faced by women. In a 1987 survey in Canada, for example, it was found that many women 18 years of age and older had used a given drug at least once in the previous year: sleeping pills—the most widely used drug (1 million), tranquillizers (900,000), stimulants (300,000), and cannabis (666,000). Almost half a million Canadian women had used cocaine at least once in their lives (Adrian, 1988).

In 1983/84, 59% of drug-related problems treated in Canadian general hospitals were presented by women. In that same year, mental hospitals found that women accounted for 32% of all treated drug problems. In 1985, 40% of all drug-related deaths were of women (Adrian, Jull, & Williams, 1988).

Eating Disorders

Anorexia nervosa is "voluntary starvation resulting in a minimum loss of 15% body weight. In women sufferers there is also an absence of menses" (DiCuio & Greene, 1989).

Bulimia is "period binge eating followed by some form of purging, such as self induced vomiting, use of laxatives or diuretics, strict dieting or fasting, or vigorous exercise" (DiCuio & Greene, 1989).

Women are 10 times more likely than men to have an eating disorder such as anorexia or bulimia. Reported concern about weight is more common among women and is a growing focus of attention at the workplace (Losee, 1988). Anorexia nervosa and bulimia usually affect young women; the mortality rate of those so affected is reported as being rather high—10% to 15% (Alexander, 1987). These disorders are not well understood; therefore, their management remains difficult.

INJURIES

Contrary to the popular view, young women experience more injuries, in general, than young men. As they grow older women have fewer injuries than their younger counterparts and fewer than older men. For example, in Canada between 1984 and 1986 male workers had three to four times as many "time-loss" injuries as female workers (Statistics Canada, 1988).

OLDER WOMEN

North American women live longer than their male counterparts, and their death rates are lower than those of men at most age levels and for most causes of death (Wingard, 1986). In Canada, the age differential is seven years: women live to an average age of 80, men to 73 (Statistics Canada, 1986). Older women, like older men, die mainly from heart disease, cancer, and stroke.

Although older women have fewer life-threatening illnesses, they experience more illness, tend to be affected by one or more incapacitating chronic conditions, and report more poor health (Wingard, 1987). Several common health problems that occur among older women, but are not exclusive to that group, are incontinence, prescription drug use and misuse (which can generate mental and/or physical health problems), depression, senility, and Alzheimer's disease (a disorder of the brain causing loss of memory and serious mental deterioration). Incontinence is a problem for about 15% of older women (Resnick, 1987). Alzheimer's disease affects men and women equally; 300,000 Canadians have this disease, which causes about 10,000 deaths each year (Alzheimer Society of Canada, 1988).

Older women utilize community health services more than older men and are institutionalized more frequently.

ETHNIC MINORITY WOMEN

Ethnic minorities are playing an ever-expanding role in North American society. Today in the U.S. they comprise close to one-quarter of the population. One in five women in the United States represents a minority (Lin-Fu, 1987).

Today in Canada we have approximately two million Canadian women who were born outside of the country. In 1985 it was recorded that immigrant women had a workforce participation rate of 55.6%. These women have a consistently higher participation rate than Cana-

dian-born women (Ng & Estable, 1987).

In general, minority women have health problems and "high risk factors" similar to other women. However, some women's health problems are unique to given minority groups. For example, native women have special health problems related to poor nutrition and alcohol abuse. Black women have a higher incidence of diseases such as hypertension, cardiovascular disease, diabetes mellitus, cancer, sickle cell disease, and systemic lupus erythematosis. Also both infant and maternal mortality rates are much higher in this minority group than in the general population.

WORKSITE HEALTH HAZARDS

Health hazards at the worksite—especially reproductive health hazards—are a major concern to working women.

Although in recent years there have been major developments in legislation and regulations in this regard, substantial, far-reaching rigorous scientific research on worksite health hazards remains unavailable. Simply put, there are few definitive answers to the frequently posed questions about health hazards put forward by women, or by men for that matter. Obviously, this is an extremely complex and diverse field. Therefore, much specific research will have to be conducted before clear directions can be set. However, those three areas of concern, when one speaks of women's occupational health and safety, are: stress, reproductive hazards, and hazards for pregnant women (Bennett, 1984).

Approximately 80% of working women hold jobs in six major occupational groupings—clerical workers, service workers, waitresses, hairdressers, saleswomen, health workers, administrators, and teachers. Such employment determines the nature of the hazards to which most working women are exposed. Some of the key health hazards that have been identified in these occupational groupings are: poor workspace design; poor lighting; noise or vibration; repetitive motions; heavy lifting; poorly designed video display terminals (VDTs); exposure to chemical and biological hazards. Some of these factors also constitute reproductive hazards. Also of concern are conditions related to the organization of work, such as lack of job control, job insecurity, inadequate staffing levels, and shift work.

With the growing number of women of fertile age in the workplace, the impact of hazards on reproductive health is a primary

concern. With regard to VDT emissions and abnormal pregnancies, it appears that current standards are outdated and do not adequately protect VDT operators. A number of studies indicate that real health risks for pregnant women exist with these machines. Also, adverse affects such as cataracts, skin rashes, and stress-related diseases have been noted (Bertinuson, 1985).

WORKSITE HEALTH PROGRAMMING

Historically, employee health and employee health promotion tended not to be a priority in most organizations in spite of the fact that the structural and economic well-being of organizations turns on the axis of employee health. Lack of attention has been especially the case in private sector organizations. For example, a recent study of large American corporations revealed that their total investment in health promotion was 0.11% of net profits, compared with 24% of net profits expended on health insurance (Herzlinger, Schwartz, & Calkins, 1985/86). More significantly, the health of female employees appears to have been even less a priority. This attitude stemmed from traditional—and male dominant—management and labor's perceptions of female workers and has been reinforced by the fact that, among other things, women tended to be located in lower-echelon, non-decision-making jobs, tended not to be unionized, tended to be wage earners rather than salaried employees, and tended to work part-time or seasonally.

Arguably, it could be said that the individual employee, man or woman, is ultimately responsible for his or her health and well-being. However, it has become increasingly clear, and more generally accepted in organizations, that the employer has an instrumental role to play in assisting employees to promote and maintain health and, where health or social problems occur, in assisting with problem intervention. The position is rooted in the realization that health affects work and work affects health (Santa Barbara & Coshan, 1988).

Now cognizant of medical research suggesting that the greatest indicator of health and longevity is job satisfaction, employers have begun to take the health of employees more into account and as a result positive steps are being taken in terms of female employee health issues (Stanley, 1987). Also, employers are realizing that health and illness are, in large measure, shaped by education as well as economic, cultural, and social conditions. Too, employers understand that all employees, sooner or later, experience "life event stress" that is likely to have impact upon

performance, work relationships, and quality of life at the workplace (Rogers, 1984).

Progressive employers are now attempting to institute health promotion programs for their employees that range along the continuum of care from health promotion to problem resolution—and in a universal fashion. The worksite is rapidly proving to be a logical and meaningful point at which to: (1) foster health promotion among female employees; (2) assist women who are at high risk for given health problems to contain or manage those lifestyle factors that are putting them at risk; and (3) directly assist those who are experiencing full-blown health problems. Such employers are obviously sharing the observation that women constitute such an important part of the population that public health issues that affect them are priorities for us all (Norris, 1987).

Clearly, worksite leaders, be they managers, labor representatives, or health specialists, have a moral, social, and economic responsibility to ensure that all workers, and in particular female workers, are empowered to take charge of their personal health when they are able to do so and to ensure they obtain proper guidance, assistance, and support when they are unable to do so. But how can the health of female workers be promoted at the worksite? Well, simple things do make a difference.

The employer can encourage and provide support for female workers to come together to discuss health-related matters (Hennessey, 1983). Networking among women can instil confidence and allow the women to take control of their health. Such networking should be encouraged not only within the worksite but between the worksite and community-based women's services. Worksite leaders should never consider health problems as personal failings. They should be cognizant of the interplay between the social context of women's lives and their health.

In addition, the employer, by remaining sensitive to changes in public health measures, can provide educational opportunities and outreach programs—often very inexpensive—that can help women of various ages and cultural and educational backgrounds to adopt health practices that maintain good health through the various life stages. Women, as wise consumers, can take charge of their health by being informed, seeking counsel, using community resources, and having the

opportunity to communicate with other women. Assisting female employees in planning for health care needs in later life is another important aspect to the employer's role. There is every reason to believe that women at the workplace will respond positively to such initiatives (Rosenbaum, 1986).

Experience tells us that one must expect to meet with at least some resistance in promoting such innovative programs at the workplace. However, positive workplace change takes time; the more significant the change, the longer it may take (Mansell, 1981).

COMPREHENSIVE CORPORATE HEALTH PLANNING

In order for a contemporary organization to address employee health needs in an efficient and effective manner—for humanitarian, administrative, or financial reasons—it is essential that a well-rationalized and equally well-implemented comprehensive corporate health program be instituted (Kiefhaber & Goldbeck, 1983).

Such a comprehensive program should be based upon a clear and objective understanding of the worksite and workforce. As experience demonstrates, it should be developed by a delegated employee committee representing management and labor, men and women (Herzlinger, Schwartz, & Calkins, 1985/86). Further, and most important, the program should be developed in such a fashion that, based upon identified employee health/social needs and preferences, it incorporates the reinforcement of existing worksite health and social initiatives and services that are deemed to be appropriate and desirable and the incremental introduction of new and innovative programs and services where needs dictate.

Obviously, human, material, and financial resources predicate the extent to which a worksite can respond to employee health needs. Therefore, these needs will likely have to be dealt with in a prioritized fashion. The challenge for an organization in clearly articulating its corporate health care program is to critique existing initiatives to ensure they meet identified health and social needs of employees, male and female, individually and collectively, and, if desirable, to generate required health programs/services where none currently exists. Conceptualizing in writing the rationale for these various "wellness" initiatives and clarifying the relationships among them are important components in this process.

When an organization undertakes the development of a compre-

hensive corporate health plan and program, it automatically takes into account the health needs, risks, and preferences of its female employees—and at all levels. The result can only be more sound health promotion initiatives for female employees and a resultant improvement in their health, general sense of wellness, and ultimately productivity.

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STRESS AND THE WORKING WOMAN

JEANETTE J. COCHRANE

The past few decades have witnessed the movement of great numbers of women into the workforce. The traditional family structure has been superseded by the dual-career or two-income family. By the end of 1987, the Canadian labor market included 5.2 million women between the ages of 20 and 64, for a female participation rate of 66.6%. At that time women constituted approximately 43% of the total labor force. Approximately 75% worked full-time (an average of about 39 hours a week), with the remainder working part-time (an average of about 15 hours a week) (Statistics Canada, 1988).

During this same period there has been a proliferation of research into occupational or work-related stress and job satisfaction. However, despite increasing numbers of women in the workforce, this type of research has been predominantly about men (Haw, 1982).

EFFECTS OF PARTICIPATION IN THE WORKFORCE

Most of the research regarding women has investigated the effects of participation versus non-participation in the labor force. Does working enhance a woman's physiological and psychological health? Obviously the answer depends on a variety of factors. Employment by itself bears little relation to happiness or distress. It is the interaction of work with other factors that is critical. The relationship between psycho-

logical well-being and employment is mediated by a woman's occupational involvement; her commitment to being in the labor force; the quality of her physical and psychological job environment; the quality of her non-occupational environment; her childcare and household responsibilities and how much responsibility her spouse or partner accepts for child and household tasks; sex-role beliefs; and the number of roles she occupies (Barnett & Baruch, 1985; Gove & Tudor, 1973; Kessler & McRae, 1982; Krause & Geyer-Pestello, 1985; Parry, 1987; Sekaran, 1982, 1986; Warr & Parry, 1982a, 1982b).

Studies have also investigated the effects of working on women's life satisfaction and marital satisfaction. The relationship of satisfaction to participation in the workforce is mediated by the same variables as those that influence a woman's psychological and physical well-being. The quality of her job and non-job environment and her commitment to working can be expected to have an influence on a woman's life satisfaction. Commitment to work, level of education, family status, and income are all interrelated and have been studied in relation to employed women's satisfaction with life and marriage. These studies have found that education has an effect, but the evidence is mixed. A study by Burke and Weir (1976) found that highly educated working women were more satisfied with their marriages than comparably educated housewives. Other studies have found that more highly educated women are generally more satisfied whether they are employed or are housewives.

However, less-educated housewives are more satisfied than less-educated working women. One can postulate that well-educated women will probably work from choice and will have better jobs. The other variables that have been investigated have been family income and work commitment, but their effects on satisfaction are not clear. It does appear that wives who work from choice rather than necessity, those whose husbands are favorable to their working, and those who work part-time are happier in their marriages than are full-time housewives.

In general, the available studies have indicated that participation in the labor force exerts a positive influence on women's physical and psychological health. Employed women fare better emotionally and have fewer psychiatric symptoms and greater life satisfaction than housewives who are not employed. Housewives also appear to be slightly more likely than employed women to be users of minor tran-

quillizers, sedatives, sleeping pills, or antidepressants (Cooperstock, 1976; Health & Welfare Canada, 1988; Parry et al., 1973). Employment increases a person's social support network, increases feelings of self-worth or self-esteem, and provides one with a sense of accomplishment in a socially valued activity (Nathanson, 1980).

The problem with much of this research is the difficulty in determining cause and effect. It is necessary to consider the selection factor or the "healthy worker" effect. There is evidence that women who are healthy are going to take on more roles. Women with physical and/or psychological problems will restrict themselves or be restricted by others. Women who are physically or psychologically ill may not be in the labor force, may not get married, or may choose not to have children.

IMPACT OF EMPLOYMENT ON HEALTH

The discussion to this point has been primarily about the general effect of employment versus non-employment. However, most of the occupational stress research has investigated the impact of the job or components of the job on health. The problem, as noted by Haw (1982), is that this research has been predominantly about men. These studies have found that the physical and mental health of workers is directly influenced by work experiences.

There are certain circumstances or characteristics that, when present in a job, are considered to contribute to psychological distress, physical ailments, and job dissatisfaction. These have been well documented in the occupational stress literature and include such factors as career opportunity, role ambiguity and role conflict, relationships with supervisors and co-workers, pay and benefits, job security, autonomy, input, variety and interest, workload, etc.

The work environment may be detrimental to the health of workers when exposure to job stressors is prolonged and unrelieved (Holt, 1982; Kasl, 1978; Selye, 1975). Work stress has been related to physical conditions such as coronary heart disease and peptic ulcers; psychological or emotional problems such as depression, anxiety, irritability, and apathy (Cooper & Marshall, 1976); and behavioral responses such as smoking and excessive use of alcohol and drugs (Conway et al., 1981; DeFrank, Jenkins, & Rose, 1987).

There is no reason to believe that women will experience or respond to job stressors differently from men. However, the majority of women occupy jobs that by their nature contain many potentially

stressful conditions. This stress is due in part to their socialization. In Western industrialized society, labor activity is divided into two main categories—that which is considered "productive" and is assigned a market value and involves the production of goods and services, and non-productive work that has no market value and includes child rearing, home maintenance, and other domestic activities. Women have been traditionally raised to be nurturers and have always been involved in the second sphere of activities. Women are expected to care for everyone else's needs before their own. In 1983, 77% of all females worked in just five occupational groups—clerical, service, sales, medicine and health, and teaching (Statistics Canada, 1985). The expected, typically female prerequisites of these jobs are different expressions of the mothering or nurturant functions. They are regarded not as skills but as attributes of female socialization, which are typically undervalued in the labor market. In general, women occupy these low-level and lower-paying jobs, which often entail potentially stressful conditions such as poor physical environment, discrimination, job insecurity, and lack of opportunities for career advancement.

Two major studies in the United States have investigated job stress in women and its relationship to physiological outcomes. The Framingham Heart study (Haynes & Feinleib, 1980) and the Tecumseh Community Health study (House et al., 1986) both suggest that subjective reports of job pressures and tensions may be related to poor health behaviors such as smoking, drinking, and obesity, and to the prevalence and incidence of morbidity in women. The Framingham study found that women clerical workers who were married to blue-collar workers, who had children at home, and who had unsympathetic bosses had twice the incidence of coronary heart disease as other categories of workers and housewives. The Tecumseh study found similar evidence for female clerical and sales personnel.

Other researchers have studied women in professions such as nursing, teaching, social work, medicine, and law. Generally speaking these women enjoy their work and derive great satisfaction from it. However, some studies have reported that women experience prejudice in training programs and employment situations ranging from being discouraged or prohibited from pursuing their careers, to receiving lower incomes than their male counterparts (Welner et al., 1979). Women in these professions also report far more career disruption due to child rearing and family concerns than do males. For example, women more often than their spouses report putting a hold on their career aspirations

during the child-rearing phase of their lives (Zappert & Weinstein, 1985).

GENDER AND JOB SATISFACTION

Several large-scale American and Canadian surveys have found that men and women do not differ with regard to overall evaluation of job satisfaction (Bokemeier & Lacy, 1986; Murray & Atkinson, 1981). This finding is somewhat surprising since, generally speaking, women are paid less, occupy lower-status jobs, and experience greater conflict and overload between their work and non-work roles. A possible explanation is that women have been socialized to expect less and are thus satisfied by what they get (D'Arcy, Syrotuik, & Siddique, 1984).

Although men and women do not differ with regard to overall levels of satisfaction, the studies suggest that they derive job satisfaction from different sources. In general it appears that men attach greater importance to extrinsic features of the job such as pay and security, opportunity for promotion, autonomy, and accomplishment or achievement (Murray & Atkinson, 1981). Relative to men workers, women report lower levels of autonomy, opportunity, and pressure in their jobs, yet they are equally satisfied with their jobs. The consistent finding for women is that they place greater importance on social aspects of the job, for example their relationship with their supervisor and co-workers, with some suggestion of the importance of a varied and interesting job.

MULTIPLE ROLES

One of the major stressors of employment particularly for women is the interaction between events at work and events at home. No one works in a vacuum. The stressors we encounter in one area of our lives are certain to have an impact on other areas of our lives. Since most working women adopt several roles simultaneously (e.g., wife, mother, employee), they will be exposed to a larger number of potentially stressful situations and events. The major difference between men and women in the workforce is not in how many roles they occupy—both take on the roles of worker, spouse, and parent simultaneously—but in the degree of responsibility that is undertaken in carrying out these roles. Traditionally women have assumed greater responsibility for roles associated with childcare and household maintenance. The common finding in studies of working women is that regardless of the woman's occupation, she bears primary responsibility for home and childcare.

It appears that when marital or household stressors occur, they have more severe consequences for physical health and psychological well-being than do stressors in the work situation (Kandel, Davies, & Raveis, 1985). This finding was supported in a study by Cochrane, MacBride, and Freeman (1987), which found that non-work-related stressors were more strongly related to psychological distress in a group of female clerical workers than were the job- or work-related stressors.

Gove and Tudor (1973) hypothesize that women who work will have increased psychological strain due to conflicting demands between work and family. However, research findings have been somewhat contradictory. Some investigators found that employed mothers of young children exhibited the highest levels of stress. Others (e.g., Kandel et al., 1985), found the lowest levels of depressive symptomatology in women with the most complex role configuration—that is, women who combined the roles of wife, parent, and worker.

Recent research into multiple roles seems to indicate that it is not the number of roles but the satisfaction or quality of experience within the roles that determines the degree of stress or stress-related illness a woman experiences (Barnett & Baruch, 1985). In addition, research indicates that sex-role attitudes play a part in predicting anxiety and depression in working women. Parry (1987) investigated the relationship between women's sex-role attitudes and their psychological symptoms and feelings of self-esteem. She found that liberal sex-role attitudes were associated with lower anxiety in employed mothers and with higher self-esteem in non-employed mothers. Higher anxiety was associated with traditional attitudes in employed mothers and with liberal attitudes in non-employed mothers.

Despite the seeming logic of the work overload argument, there is very little good empirical evidence in support of the relationship between multiple roles, stress, and illness. However, studies and anecdotal accounts continue to support the belief that attempts to combine full-time employment and motherhood will lead to overload and role strain resulting in common symptoms of fatigue and irritability. The many tasks involved in carrying out these roles leave women little time for relaxation and for satisfying their own psychosocial and personal needs. There is some evidence that part-time employment is more compatible with child rearing than is full-time employment (Thomson, 1980).

The "cultural imperative that career women must still prove

their femininity by being good mothers and wives" (Weitzman, 1982, p.39) remains true in this advanced era of female opportunity and equality. Barnett and Baruch (1985) report that it is the "mother" and not the "spouse" role that creates potentially damaging stress for the working woman. Children require continual care and supervision. Their needs cannot be put off until a more convenient time. Even with the help of a relative or spouse, or the availability of good childcare, mothers who work have a double workload. Studies consistently indicate that fathers play a lesser role in the routine aspects of childcare than do mothers. A study by Googins and Burden (1987) reported that employed mothers spend almost twice as many hours per week on home and childcare tasks than do their spouses. Time spent in parenting is added on to time spent in paid employment. Since 65% of working women have children under the age of 16, and 60% have preschoolers aged 3 and under, there are large numbers of women potentially at risk for physical and psychological ill health.

At a time when their children are entering adolescence and requiring less intensive care and supervision, people are often faced with the increasing needs of their aging parents. In this "sandwich generation" the needs of working mothers are "sandwiched" between those of their "adolescent children who are seeking increasing independence and those of parents who are faced with loss of independence" (Myers, 1988, p.332). There is consistent evidence that families provide the overwhelming majority of services to the elderly (Doty, Liu, & Wiener, 1985) and that daughters are predominant in the provision of these services (Brody, 1981; Stone, Cafferata, & Sangl, 1987). Most of these women are in the labor force at the time that their parents require assistance. The provision of emotional and instrumental support increases the woman's role demands and can lead to role overload and strain. These "filial" demands, when added to employment, marital, and parenting demands, leave a woman with very little time for fulfilling her own psychosocial needs. Several investigators have documented declines in health, particularly in the area of mental health, in caregivers of aging parents.

STRESS MANAGEMENT

Women should not relinquish all responsibility for managing their own stress. It is important for a woman juggling several roles to develop strategies to organize her life so that the workload is distributed equitably and with a minimum of conflict. It is also essential for mental

and physical health to set aside protected time for relaxation and social and recreational activities. However, it is equally important that organizations recognize their responsibility in ameliorating work-related stressors and developing programs to help their employees. It is in the interest of the organization to address the needs of its employees both from a humane standpoint and from the standpoint of the ability of the organization to carry out its mission, for the accumulation of stress may become manifest in work dissatisfaction, illness, absenteeism, and accidents in the workplace. It is beyond the scope of this chapter to enter into a discussion of stress management techniques. However, the following is a short list of ways in which organizations can be helpful to women who are combining employment with other stress-producing roles:

- Allow flexibility of work hours and encourage job sharing. These concepts and practices are particularly important for mothers of young children or those who are responsible for the care of elderly parents.
- Provide or facilitate the development of subsidized daycare centres at or near the place of work. Convenient daycare centres will do much to reduce the hours spent commuting from home to the childcare setting to work and back, and allow the mother to spend more time with her children.
- Provide an understanding and supportive environment that sponsors educational experiences such as workshops and seminars dealing with stressors specific to this group of employees.
- Provide fitness and other health promoting programs geared to the needs of women in the workplace.

CONCLUSION

This chapter has provided a brief overview of current knowledge about the stress of working women. It would appear that while women experience similar job-related stressors to men, they must deal with additional household, childcare, and other family-related tasks. It is probable that women will continue to enter the workforce in increasing numbers. It is also likely that they will continue to shoulder the greater share of household and family responsibilities. The data in this burgeoning research field show that women's changing roles will continue to produce potentially stressful, conflict-laden situations. These stresses constitute serious problems for corporations, health care and social service providers, and society in general. It is essential for these

institutions to collaborate in producing programs and policies that are more responsive to the needs of working women. In the long run these efforts will result in healthy and productive families, corporations, and societies.

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DOMESTIC VIOLENCE: THE ROLE OF THE WORKPLACE

CHILD ABUSE PROGRAMMING AT WORK

DIANE PONÉE

The subject of child abuse, inserted in a publication about women and wellness, may come as a surprise to some readers. What are the unique connections between this social problem and gender? Further, what place does this issue occupy in a book on life in the workplace? This article attempts to build bridges between these various dimensions of social and health programming.

CHILD ABUSE: A GENDER-RELATED ISSUE

Prior to the 1970s, child abuse was understood primarily as a medical problem initially identified by physicians, who played a leadership role in developing approaches to dealing with it. It was also a legal concern of child protection authorities, although their leverage for action in those days was minimal. Generally, it was not conceptualized in sociological terms and even less so within the framework of feminist analysis. Therefore, gender was not much of an issue. Male and female children, it was observed, were battered fairly equally by parents of both sexes. Sexual abuse of children was virtually not acknowledged, let alone viewed in gender-related terms.

However, a number of realizations now surface as a result of recent insights from the women's movement. One of them is the heavy parenting burden that faces most women. In many surveys of two-parent families, of which a popular one is quoted here (*Better Homes and*

Gardens, 1982), in families where both parents work, mothers report carrying 60% of the direct childcare responsibilities, 54% of peripheral duties such as attending school meetings, and 64% of duties such as taking children to the doctor. Fathers' responsibilities are respectively 11%, 18%, and 13%. Older siblings and other relatives account for the balance. That 85% of single-parent families are headed by women (National Council of Welfare, 1986) further solidifies the argument that numerically at least, women are the prime caretakers of children. Physical abuse and neglect are believed to occur more frequently and to be more serious in the population of children under age 4, often an age where children spend more time with their mothers, irrespective of familial arrangements.

In the early 1980s, the women's movement drew attention to a particularly alarming social problem, that of child sexual abuse, and affected significantly our understanding of the issue and our intervention strategies to this day. Feminist analysis of this problem is rooted in the belief that children are abused sexually because they are powerless, and that society, through its values and institutions, has vested power in the hands of men (Rush, 1980). Like women, children become the objects of that power. It is not simply by chance that child sexual abuse victims happen to be predominantly girls and that offenders are principally men. This situation stems from men behaving as exploiters of power and of women becoming the passive recipients of that exploitation. The criminal justice system has also reinforced this message in the past by setting out legal provisions that made it next to impossible to successfully prosecute and charge offenders. Today, recent amendments to the laws of both Canada and the United States have addressed this imbalance. Such changes include allowing children to testify and receiving a child's testimony even though it is not corroborated by another witness.

It is clear that gender-related considerations are inherently tied to the phenomenon of child abuse and have led to major social changes in many of our institutions. The workplace too may become a site for this form of social change. If we consider the large number of women who are in the workforce—as prospective parents, as caretakers of children, as spouses or mothers of potential abusers, as survivors of abuse in their own past—the implications for gender-related preventive policies and for differential clinical issues in the workplace are significant.

CHILD ABUSE: ITS RELATIONSHIP TO THE WORKSITE

The subject of child abuse probably surfaces informally in the workplace on a near daily basis, if only as coffee break talk to discuss the latest made-for-TV drama or to share a story about the neighbor who leaves her 3-year-old unattended. Beyond these socially acceptable exchanges, child abuse—when it is the employee's personal problem—remains largely confined to the intimacy of the home or to the confidential safety of a very close relationship. Yet the odds of child abuse having occurred in the lives of our fellow workers are quite considerable. It is a problem that affects both sexes, all socioeconomic levels, and most age groups. For instance, in a city of half a million population, physical abuse or neglect may be occurring up to 1,000 times per year.

In the case of sexual abuse, consider the findings of Dr. Robin Badgley's federally commissioned report *Sexual Abuse Against Children and Youths* (Government of Canada, 1984): some time before reaching the age of majority, one in two females and one in three males will be the target of unwanted sexual acts ranging from voyeurism to actual assault, and in 80% of the cases the perpetrator will be a person in a position of trust such as a blood relative, a teacher, or a friend of the family.

In the matter of child mortality, children die annually at the hands of their parents, exclusive of deaths that may have resulted from negligence.

There is no reason why any of these tragedies need occur. With statistics such as those noted, the prevalence in the population of persons who have been caught in the web of child abuse either as victims, offenders, or relatives of either party reaches unsettling proportions.

If child abuse is indeed part of an employee's current or past life experience, it would be hard to believe that the problem is dropped abruptly outside the plant door at the start of every shift and collected at the other end, just as it would be difficult to convince anyone that the stresses and strains of the boardroom or the assembly line are left behind when the employee heads home every day. Conventional wisdom would lead us to believe that the latter is more prevalent: that is, more job-generated pressures are carried home than the reverse.

Either way, the interdependency of home and work can be played out in certain parent-child relationships and conversely in work-

based interactions. This is becoming such a widely recognized fact that in its 1984 grant program, the United States Department of Health and Human Resources invited project proposals that would develop and test family social services in the workplace, thus creating by way of matching funds an incentive for the worksite to become a bona fide social service delivery outlet and part of the support system to families. In a similar vein in Canada, the annual First Ministers' Conference held November 26-27, 1987, addressed this issue by releasing a policy statement titled "Work and Family Responsibilities." According to *Perspectives* (Status of Women Canada, 1988) the document:

> recognizes the leadership role governments must play in creating a work environment that will assist workers in fulfilling family responsibilities. First Ministers directed federal, provincial and territorial Ministers Responsible for the Status of Women to develop strategies to deal with the new roles of women and men.

In the fall of 1988, worksites across Canada were asked to take part in a study, led by the Conference Board of Canada, that will explore the challenges Canadian workers face as they balance the demands of their work and private lives. Approximately 10,000 employees in 1,600 companies across Canada have been surveyed.

In 1985, one Employee Assistance Program coordinator in a Canadian federal department introduced in her training program for EAP counsellors a two-day curriculum on family violence (child abuse and wife assault) to assist them in detecting and managing these cases and to review strategies for primary prevention. Since that time, it has been repeated periodically in the public service, following various formulas. In 1986, the Family Violence Prevention Division of the Department of National Health and Welfare funded a demonstration project to measure the incidence of family violence among employees in selected worksites and to lay the groundwork for a public awareness program and a training curriculum for EAP personnel. These events herald new developments regarding corporate action towards families in general and child abuse in particular.

On August 31, 1988, the Kingston *Whig-Standard* featured the headline "Family violence becomes concern of corporations around the U.S." and went on to reproduce from the *New York Times* an article that describes some of the programs developed by American companies to educate their employees on the question of family violence. Everett Koop, the well-known former Surgeon General of the United States, is

quoted as referring to the "effects [of family violence that] spill over into the work place."

Because the work environment has taken on a major role in the social fabric of society, it may well become tomorrow a standard part of the network of social services—as it is in many industrial sectors in France, for example—a place of nurturance, just as the paycheque is today a source of material sustenance.

Until the beginning of this decade, the subject of family violence had barely found its way into the EAP literature. However, things are beginning to change. For example, in 1984, the Chicago-based National Committee for the Prevention of Child Abuse and Neglect published *Strengthening Families Through the Workplace*, a monograph by Peter Coolsen. In September 1984, Coolsen assisted the Fifth International Congress on Child Abuse and Neglect (Montreal) in organizing an event where representatives of the corporate sector met with practitioners in the field of child abuse to discuss models by which the worksite can be a partner to the helping services in the prevention of child abuse. EAPs are a principal avenue for this type of preventive intervention.

WHAT CAN EAP PERSONNEL DO IN THE FIGHT AGAINST CHILD ABUSE?

At this juncture, it may be useful to define child abuse and to list the types of clinical situations that EAP counsellors may encounter in their work or that supervisors or referral agents may be in a position to identify.

There are basically three forms of child abuse: physical, emotional, and sexual. In all three forms, abuse may be the result of acts of omission (failing to protect a child or failing to provide for the child) or acts of commission (deliberately harming a child).

Physical Abuse. Children may be neglected (usually by acts of omission) or beaten. Corporal punishment is a debated topic; in some provincial child welfare jurisdictions it is being interpreted as abusive, but in certain Children's Aid Societies there is a shying away from investigation unless there is actual physical harm to the child. As an aside, it is interesting to note that the Criminal Code of Canada's Section 43 allows for corporal punishment provided the "use of force [is] reasonable." The adjective is not defined, however. Advocates of children's rights view this as a double standard, since under no circum-

stance is physical force allowed on adults, "reasonable" as it may be.

Emotional Abuse. Emotional abuse also manifests itself in the same two ways: serious understimulation and emotional neglect, or actual cruelty of the type that subjects a child to a harsh psychological environment or maltreatment.

Sexual Abuse. Sexual abuse is a complex concept that includes exposing children to harmful sexual information or behavior, involving them in such behavior, or failing to protect them from either. Associated with the term are various subgroupings: incest (abuse by a relative, defined in the Criminal Code of Canada); abuse by "a person in a position of trust"—a new concept in the Criminal Code; and abuse by a stranger. Pornography (e.g., showing such to children or involving them in the production) and child prostitution (e.g., living off the avails or using the services of juvenile prostitutes) are the other well-known forms of child sexual abuse.

The types of child abuse situations one is likely to encounter in the workplace are the following:

- An employee who is an abusive parent or who is at risk of being abusive.
- An employee who is the non-offending parent. This term usually refers to the mother of a child who is being sexually abused. It may also include a parent of a physically abused or emotionally abused child. Relatives other than the parent may also come forward.
- An employee who is a survivor of child abuse. Childhood victims of abuse who are most likely to self-refer to you with residual emotional problems in adulthood are those who were sexually abused. They will almost always be females who are coming forward because of the sudden increased public attention to this problem. Disclosure in adult females has soared in the last five years.
- A young employee who is old enough to work but legally still a "child" under the purview of the child welfare laws or the Criminal Code and who is being abused or at high risk of being abused. The age of majority varies from province to province.

For the EAP practitioner, becoming involved in a case of child abuse is taxing, confusing, and uncomfortable, whether we are talking about an ongoing situation or one that occurred in the past. Its detection is difficult because the usual indicators are not as obvious in the work setting as they might be in other contexts and there is no quick and

effective technology available to aid detection. Since EAP personnel rarely see the child in question, the natural tendency to identify with the parent/employee may get in the way of retaining first and foremost the commitment to the rights of the child over the rights of his or her parents. EAP personnel do not come across many and frequent cases of child abuse and are only recently encountering disclosures by survivors; therefore, the opportunity to hone their skills in this particular area does not present itself every day.

Once a case is identified and reported, a complex array of services and system swings into action because the individual and his or her family are usually propelled into a state of crisis. Although EAP staff do not carry the central responsibility in the investigation and treatment of children, they may be called upon to mesh with many community systems: hospital, mental health clinic, probation, court, police, child protection agency, counselling service, clergy, school, etc.

For EAP policymakers, the need for involvement in child abuse programming may appear still more remote. It will be seen as a problem that is discomfiting. The idea of involvement may meet with resistance, disbelief, or fear by the board or by senior management, such that public education programs for instance may be seen as (a) superfluous in an organization that surely houses only model parents or adults who have never been victimized; or (b) inappropriate in the case of sexual abuse, which is a subject that one does not bring out of one's own home.

Globally, the role of EAP personnel in the fight against child abuse is:

1. First and foremost, to report any suspicion of abuse of a child to a local child welfare authority or to the police. This is a duty required by law.

In Canada, as in the United States, child abuse is regulated by two distinct legal frameworks: the civil code in the form of provincial or territorial child welfare statutes; and the Criminal Code (Horowitz & Davidson, 1984; Wilson, 1982).

One of the important provisions of the civil code is that of *mandatory reporting*. All provincial and territorial jurisdictions in Canada except Yukon have a law in their child protection statutes that obliges citizens to report any suspicion of child abuse under penalty of law. The penalty for not reporting varies: fines of from $500 to $1,000, jail, or both.

To date, the legal system in Canada has not been able to prove satisfactorily that persons who knew about suspicious circumstances deliberately failed to report them, and therefore attempts at prosecution of such persons have failed. In the United States, however, one reads that such cases have been prosecuted successfully.

It is important for all to know of this law: practitioners, policymakers, and employees alike. More important yet, in certain jurisdictions such as Ontario, New Brunswick, Manitoba, and Quebec, professional persons especially are bound to report under penalty of jail, a fine, or both. Professional persons in Alberta and Manitoba who fail to do so will be reported to their professional organization. Equally important to note is that it is not necessary to have proof of abuse. Reasonable suspicion constitutes grounds for reporting.

A case of child abuse can be reported by calling the local child protection authorities—in most centres the telephone number is in the listing of the Emergency Services section on the first page of the telephone book—or by calling the police.

The Criminal Code, while it contains specific clauses that define child abuse and its sentencing alternatives, does not have a mandatory reporting clause.

Once a professional person notifies the authorities of a suspected case, and if that person is in a position to become or remain involved with the child or family members—as in the case of an EAP staff person—a range of responsibilities may be expected of that person. Some of these are reviewed briefly below. The identity of the person who reports a case to a child welfare agency is kept anonymous, and such a person could never be charged with breach of confidentiality or libel/slander unless the reporting had been done maliciously.

2. To work during detection/disclosure and follow-up phases with the professionals and systems that operate as a multidisciplinary network in the management of a given case situation.

This article cannot provide the EAP practitioner with a detailed account of the steps that unfold when a case is reported to a child welfare agency or to the criminal justice system. What is important to know is that, in effect, either or both of these systems may become involved. Traditionally, child abuse cases tended to find their way to family courts only—via application of the civil (provincial/territorial) laws of child

protection—except for the very serious cases, which were investigated by the police and prosecuted in criminal court. Today, there is a marked trend toward the criminalization of all forms of child abuse, particularly sexual abuse. There is some debate as to the relative benefits and liabilities of calling upon the "heavy hand of the law," and only comparative research will eventually resolve the controversy.

The major differences between the two systems is that the family court is not based on an adversarial system; therefore, there are no defendants, no one is found guilty, and no one is sentenced. Rather, a child is or is not found in need of protection. In criminal court, there is a defendant. The burden of proof under the Canada Evidence Act is more rigorously applied, and in general the level of intimidation and stress is much greater for all parties concerned, including witnesses who are called upon to testify, and particularly child witnesses. The newly proclaimed Bill C-15 makes provisions for measures that will attenuate the trauma to the child; for instance, the accused can be asked to sit behind a one-way mirror or other arrangement where he or she can attend to the court proceedings but be invisible to the child. Of course, not all courts are so equipped.

Once a case is reported, child welfare authorities in most Canadian jurisdictions are obliged to initiate an investigation within 24 hours. If indicators of risk are found, or if in fact the authorities identify evidence to the effect that a child is being abused, they may or may not take the case to provincial or criminal court, depending on the degree of impending risk to the child. (Imminent danger can cause them to apprehend a child without warrant, provided they go to court within a short time, such as five days in certain jurisdictions.)

Whether they take a case to court or not, their first responsibility is to obtain thorough documentation on the circumstances surrounding the child and the events in question; as a clinician, you may be called upon to provide information, and you might even be called to give testimony in court, although that is not likely. Participation in case conferences at a child abuse committee is almost always requested of key disciplines such as physicians, mental health professionals, and teachers, for the open exchange of information; this is essential so as to develop a complete picture of the family situation, for there is rarely a witness to the actual offence. An EAP counsellor may be invited to present a written or verbal report to the committee or team.

After the detection phase, and in the follow-up period, a parent's access to environmental supports by way of a constructive and sympathetic ear is crucial. This task can be formidable at times and is best shared by more than one professional or lay therapist. EAP counsellors may be among these professionals. If you have as a client a parent who is currently in this process either as the non-offending parent or perhaps even as the offender, you will undoubtedly find the person very traumatized. Particularly in the case of the mother, who is almost always the non-offending parent, it is extremely important to provide her with the support needed so that, in turn, she will find the strength and ability to serve as a support to her child, in most cases a daughter.

It is not particularly helpful to adopt a stance that was so popular for many years in traditional therapeutic circles (Masson, 1984) whereby the mother was often seen as having willingly cast a blind eye to the incestuous situation because it met her personal and sometimes selfish needs. Some readings on family process and incest are available (Trepper & Barrett, 1986), although there is not yet a profusion of literature on the therapeutic aspects of the problem.

Also, what you may wish to remember is that the court process can be a therapeutic one for both the victim and the non-offending parent, and one in which the peripheral counsellor can play a role. Post-court events are particularly critical in cases of intra-familial abuse whether the offender is forbidden to reunite with his family as a result of a conviction or returns home as a result of a non-conviction.

In the case of an employee who discloses sexual abuse that occurred in childhood, the involvement of EAP personnel is entirely different. This is a highly critical moment in the life of the survivor and one where access to the proper type of assistance is essential. For a counsellor who has never handled such a case, the therapeutic options that are currently being explored by specialists are very complex and in many cases not always in the repertory of usual techniques—for example, hypnosis and imaging. Readings and consultation with therapists who have become familiar with these types of cases would be essential, if there are no specialized services in the community to which survivors could be referred. Self-help groups and therapist-led groups are available in major centres. Sexual assault centres are often the major outlet for services of this nature, although some mental health professionals are now becoming interested in this area and are creating specialized practices.

For the EAP counsellor, the important factor here is one's comfort with the general topic of sexuality and with one's own feelings about such taboo subjects as incest. The sex of the therapist may also be a real factor, since most female survivors display very fearful and uneasy feelings toward males, or at best find it difficult to discuss the intimate facts and feelings that surround the event. No matter how abhorrent this exploitation of children may appear to us, we must nevertheless remember that many survivors still harbor very loving feelings toward their incestuous relative, particularly in the case of father-daughter incest, where the relationship may have been otherwise characterized by strong bonding. For many clinicians, it is an area into which they must initiate themselves gradually.

3. To work on behalf of families in advocating for the creation of supportive policies, particularly where these affect the quality of the work life for female employees.

Worksites are being recognized increasingly as part of the network of systems responsible for the prevention and management of child abuse. EAP personnel can serve not only as members of the professional helping community but also as catalysts in sensitizing the employer about its role in establishing programs and policies that serve to combat child abuse.

One of the most useful approaches to eliminating child abuse is to address it by way of primary prevention measures. The physical manifestations of child abuse that result from excessive disciplining or loss of control or neglect and the various emotional forms of child abuse can probably be abated by positive contributions emanating from the workplace: for instance, public awareness information about child rearing; information about the laws governing child abuse; parenting courses at noon hour; humanitarian working conditions that uphold the dignity of the employee rather than make her feel diminished; daycare on site; flexible hours (which was identified in one U.S. survey as the most favored important form of familial support by the employer). In an article on employer programs that support families, Kamerman and Kingston (1982) review the history and current range of corporate welfare programs.

Many of these policies and programs within the work environment are enabling factors toward alleviating the incidence and prevalence of child abuse. They are important adjuncts to the direct clinical

interventions that an EAP counsellor undertakes if he or she recognizes an actual or high-risk situation. The corporate sector also can play another role in the community in the form of financial support. For instance, in small, one-industry communities the local plant or company could support certain public awareness campaigns on television or in the nearby shopping mall. National companies might want to support major research initiatives in partnership with governmental or para-governmental organizations. Such initiatives are already under way in several Canadian communities. Conceivably, in industrial settings, EA programmers can initiate or support such activities by presentations to the board or by working on community committees.

The role of labor is to be recognized in this area of social programming. Traditionally, strong unions have tended to represent an all-male workforce. Blue-collar workers tend to adhere to more traditional values about family structure and child-rearing practices, although these have been changing over the years.

The notion of incorporating family-supporting policies in the broader personnel policies or in the corporate health plan may perhaps appear a novel idea in certain worksites. The responsibility and the challenge to promote these policies rests almost inevitably with EA programmers and with health care personnel. The latter have not tended to be community-based nor feminist in orientation. Thus the task of advocating on behalf of women and their children is likely to fall on the shoulders of the EA programmer, and most likely on the female EA programmer. The children of today are the employees of tomorrow, to paraphrase an old adage. The well-being of tomorrow's workforce depends on today's well-oriented employee policies.

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SELECTED READINGS AND PROGRAMMING AIDS

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A sourcebook on child sexual abuse by David Finklehor. (1986). Beverly Hills, CA: Sage Publications.

Handbook of clinical intervention in child sexual abuse by Suzanne M. Sgroi. (1983). Toronto: Lexington Books and D.C. Heath and Co.

Incest and sexuality: A guide to understanding and healing by Wendy Maltz and Beverly Holman. (1987). Toronto: Lexington Books.

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So you have to go to court. A pamphlet for middle childhood and beyond by Wendy Harvey and Anne Watson-Russell, explaining the court process and guiding children through it. Toronto: Butterworth.

Psychosocial adjustment of women who were sexually victimized in childhood or adolescence. An article by Derek Jehu and Marjorie Gazan, available from the National Clearinghouse on Family Violence, Health and Welfare Canada, 7th floor, Brooke Claxton Building, Ottawa, ON KlA lB5, (613) 957-2940.

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The secret trauma: Incest in the lives of girls and women by Diana H. Russell. (1986). New York: Basic Books Inc.

Treating child sex offenders and victims by Anna C. Salter. (1988). Newbury Park, CA: Sage Publications.

ON CHILDREN AND FAMILIES

The family: Changing trends in Canada, edited by Maureen Baker. (1984). Toronto: McGraw-Hill Ryerson Ltd.

The handbook for latchkey children and their parents by Lynette and Thomas Long. (1983). New York: Arbour House.

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WORKING TOGETHER AGAINST WIFE ASSAULT

SUSAN THOMAS GILMAN

WHY IS WIFE ASSAULT A WORKPLACE ISSUE?

A toddler is found by police after surviving for several days on an unheated porch in eastern Canada. Inside the home, the police find the bodies of his parents. Reports indicate that the father, depressed by problems at work, had been misusing drugs and alcohol and had murdered his wife before taking his own life.

We are all shocked by tragedies like this one and many of us are moved to thinking about how, given the opportunity, we could have helped that little boy who was terrorized while other Canadian children were still discovering their Christmas presents. As Canadian citizens who are enjoying the benefits of living in a relatively successful industrial nation, we cannot be lulled by our successes into ignoring what has become a social problem of tragic proportions. North American statistics indicate that one in six families has a problem with domestic violence (Strauss & Gelles, 1988). Because this is a social problem, and not just an isolated incident, we are all touched by its effects—as neighbors, as friends, as relatives, as co-workers, and also as employers. To make our society a safer and kinder place, we must work to do what we can to prevent and stop the violence.

Peter is a branch bank manager. He has been anxious lately, smoking heavily, and unable to do his work with the same amount of efficiency and goodwill as

before. His pregnant daughter, married only nine months, arrived home recently black and blue from a beating by her new husband.

Happy, well-adjusted, and successful families are traumatized when they find themselves in the midst of the crisis of family violence. They are often embarrassed to have such a problem. They don't know where to turn for help; they are fearful for the lives of their loved ones. As a result, family members are often unable to continue with daily routines and they bring their troubles with them to work.

One of the most significant reasons for absenteeism and low productivity at work is family violence (Engelken, 1987). Employers have recognized the impact that alcoholism has on absenteeism rates and productivity. A similar concern now leads managers to recognize the role that domestic violence plays in reducing the capacity of employees to work effectively. As in the case of Peter described above, the anxiety that this problem brings can seriously affect the concentration and performance of all members of a family where violence has erupted.

At noon on Wednesday, Brian puts a call through to the company's EAP unit. His secretary, Jean, arrived at work that morning with a black eye and a cut on her cheek, and obviously experiencing physical and emotional pain. She tearfully admitted to him that her husband had been drinking all weekend and that he had hit her on Sunday night. She had stayed away from work as long as she dared to avoid facing her fellow employees in such a condition.

Many working days are lost because of family violence. The victims (over half of battered women are employed outside the home) stay away because they are physically or emotionally unable to work. When they do report to work, they are often so preoccupied with their domestic problems that they cannot devote their full attention to the job. Their situation does not go unnoticed at work; whether the women try to hide their bruises or whether they discuss the violence openly, colleagues are aware that something is wrong and they too get drawn into discussions and activities that can affect the operation of the worksite.

Helen is an organized and capable employee; she could rise to a management position in her office. However, when offered the opportunity, she declines. Nobody can understand why. However, Helen's husband is jealous of her success. He buries his problems of low self-esteem in his drinking. When he drinks, he becomes violent and takes it out on her. Helen knows that if she moves ahead with her career, the likelihood of repercussions at home will increase.

In contrast to women who are battered, those who live with the

threat of violence present a slightly different profile. Women who live with the constant threat of violence spend much of their days in anxiety. They often suffer chronic health problems; their self-esteem is threatened; they avoid looking attractive and avoid appearing too successful. An unhealthy balance of power exists in their lives, and the entire family lives with unrelenting tension. The signs of this kind of victimization are even more subtle and leave employers perplexed about the strange withdrawn behavior of some staff. It is very difficult for an employer to know why a woman like Helen cannot work overtime, makes an obvious effort to dress poorly, or refuses the opportunities that will allow her to progress in her career.

Whether the reasons are purely humanitarian, or whether the goal is improved productivity and absenteeism rates, the argument for educating managers and for training employee assistance counsellors, among others, about the ramifications of family violence is very strong indeed.

WHAT IS WIFE BATTERING?

Various phrases are used to describe wife battering. Some authors purposely choose to call the problem "wife assault" to underline the criminal aspect of an assault on a partner. Others speak more broadly of woman abuse or wife abuse to emphasize that even though there may not be physical signs of the violence, the psychological effects of being terrorized, day after day, can be devastating.

> *Consider the case of Monica, whose insecure husband was always afraid that she was cheating on him. The intense daily scrutiny that she was subjected to by her husband kept her a captive in her own home, without any money to spend, with few opportunities to initiate friendships with her neighbors, and with detailed questioning about her every waking moment.*

It is generally held that one in ten Canadian women is a victim of physical assault by her partner (MacLeod, 1987). If researchers were able to identify the victims of psychological abuse, these figures would be even greater.

Those who have not yet been touched by this problem may wonder why women put themselves into such dangerous situations, or even suggest that these women provoke arguments. However, all research that has looked at the profile of victims of wife assault has failed to find any common denominators among victims. On the other hand, a profile of the battering male emerges (Hotaling & Sugarman, 1986).

The evidence suggests that the society in which we live has produced generations of men who have learned to expect certain privileges and to behave in certain ways around women. Church, courts, schools, and the workplace have all supported the assumption that men should hold the balance of power. If the scales appear to tip in favor of women, men work quickly to regain their status. On the playground, in sports, and on television, young men learn that pushing, shoving and bullying, and using violence bring rewards. However, the irony is that a close examination of bullying behavior often yields the awareness that the bully is, in fact, just another person with an inadequate sense of self, someone who does not understand that he must use his words and not his fists. Very often when we take the time to look into the background of batterers, we find out that they were abused as children, witnessed violence by their fathers, or were constantly put down and threatened.

An explanation based upon a sociological analysis can lead us to understand why family violence persists in all socioeconomic groups, amongst all age levels, and in most cultures (Strauss & Gelles, 1988). Closer examination indicates that the violence appears to be more prevalent in families that are more autocratic, more traditional, and more isolated. Increased stressors such as unemployment, economic distress, and pressures at work provoke the crises that have been waiting to occur.

HOW DOES WIFE BATTERING PRESENT ITSELF IN THE WORKPLACE?

Francine found her way to the company nurse. She complained of insomnia, low back pain, rushes of anxiety, and chronic headaches. After some time she volunteered that her husband had a problem of drinking quite a bit and admitted that she was afraid to sleep on those occasions because he often would awaken her to beat her. Despite this, she insisted that she loved him.

For the battered wife, the realization that she is a victim of abuse is very slow in coming. Even though she may have read about or heard about wife assault in the media, the connection between other reported stories and her own reality sometimes just does not happen. Battered women assume guilt for their behavior and have difficulty in realizing that they do not deserve to be beaten. They cover up to protect their children, and often avoid confronting their battering spouses about what they have done. They rationalize to reassure themselves that things will get better or that the problem will go away if they try harder. For some women, recognizing that they are victims of wife assault is

similar to admitting failure as women. For others, facing the reality of wife assault also means facing the possibility of living a life alone and without adequate financial security. In the final analysis, battered women sometimes accept that it seems safer to learn to live with the problem, to take medication to alleviate the pain, or to find excuses.

Counsellors, nurses, doctors, and social workers often complain that even when a woman recognizes that she is being beaten, she returns to the abusive situation and appears to resent further professional intervention. Transition house workers suggest that battered women often return to their shelters three or four times before they make the final break with their husbands.

Joan brought a co-worker to the EAP counsellor. The young woman spent the next hour tearfully exploring how she could help her sister who is a victim of wife battering.

Friends and neighbors are often paralysed by the realization that someone they care about is being battered, but are beset with confusion and indecision about how to intervene. Sometimes suggestions that they make to the victims are received in anger or with denial. Sometimes, when little children are in danger, onlookers are prepared to take greater risks, calling the police or seeking other ways to stop the violence. Too often, it is assumed that the woman who is the victim ought to be able to help herself if the situation is bad enough.

Rick brings to his job solid experience in the military. He is disciplined, traditional in his values, and a hard worker. Rick has been fairly successful in his job. He has reached a level of management where he is being asked to travel extensively and he has recently been selected to attend a six-month training session in a far-away city. However, he is reluctant to be away from home. He has never socialized very much with co-workers and rushes home quickly after work. Office colleagues have not met Rick's wife. Ironically, his rise in fortune at the office is accompanied by evidence that he has been drinking heavily on his lunch hour. His boss refers him to the EAP counsellor. Rick explains that he cannot leave his wife alone because she was once raped and has become sexually promiscuous.

It is unusual for battering men to present themselves for counselling. Assaultive men don't venture into conversations where they talk about their personal relationships. They tend to keep to themselves and risk very little in terms of closeness even with male friends. In their own eyes, their behavior is entirely justifiable (Currie, 1988). It is easy to get misled about the truth.

It is also easy for EAP counsellors to focus upon the problems that some men have with alcohol abuse and to ignore the problems with violence. Although it has been assumed by some that alcohol leads to abusive behavior, research has not yet identified a causal relationship. Counsellors who work with violent men report that even when their clients stop using alcohol, they continue to struggle with their tendencies to using violence. The view that has been emerging in recent years is one that recognizes that vulnerabilities to abuse alcohol and to use excessive violence reside in the same individuals because of other personality problems. Furthermore, advocates for battered women argue that to allow men to use their abuse of alcohol as an excuse for battering is to allow them to avoid taking responsibility for violence.

WHAT IS THE ROLE OF THE WORKPLACE COUNSELLOR?

Information Programs

Because of the high level of secrecy around family violence, on the part of both those directly involved and those surrounding the violence, it is important that counsellors move beyond their counselling role to develop awareness programs that reach everyone in the workplace. Such programs are now being developed in progressive worksites.

Recently, the Regional Municipality of Ottawa-Carleton conducted an education program. One group in the Social Services Division offered compulsory two-hour on-the-job discussion sessions. Employees signed up in groups of 10 to 12. A film was shown, and a crisis phone number and various pamphlets including *Fresh Start, a Handbook for Battered Women* were provided. Invited experts initiated group discussion. Nobody was pressured to speak about personal experiences, although it always happened that somebody did volunteer stories about "someone they knew." The sessions were well received, as it seems that most people welcomed the opportunity to talk about something of general concern or to voice an opinion. Afterwards, calls came from women and men seeking more information or looking for places of referral.

A second program offered by the EAP coordinator at the Regional Municipality of Ottawa-Carleton is described in *Wife Abuse Education in the Workplace: A Report and Workshop Manual* (Wolfson et al., 1988). In all, 700 regular employees participated in 30 training workshops developed to increase awareness about domestic violence and to encourage victims and offenders to seek appropriate assistance.

The EAP coordinator at the Department of Public Works (Prud'homme & Seigel, 1987) has overseen the development of a department-wide awareness program for senior managers. Workshops present an overview of the problem and prepare employers with supportive measures to help victims and prevent further violence. The departmental EAP counsellors make known their concerns about domestic violence. They maintain stocks of information about family violence and are pleased that the information is well used. The more that people know, the more they can help themselves or their friends.

Some workplace counsellors organize regular lunchtime film sessions. There are 51 different titles listed in the Family Violence Film Collection that can be borrowed at no cost from any of the distribution centres of the National Film Board.

Counselling the Victim

The examples presented earlier indicate that there are many ways that victims of batterers present themselves to counsellors. Because most battering occurs in the evening hours and at home, it is less likely that workplace counsellors will be contacted at the time of the crisis. If that were to happen, however, it would be essential to look after the woman's health and safety needs first.

Take her to a hospital emergency department where a physician will document her injuries. Latest hospital protocols provide for the use of a body map or photographs to record injuries, appropriate documentation procedures, and the preservation of clothing or specimens that might be admissible as court evidence.

It is essential to speak with the police. Since 1983 in Canada the police have been encouraged to lay a charge in the case of domestic assault. This policy decision has been coming into effect all across the country as police officers have undergone further training and as attitudes to domestic violence have been changing. The woman also can lay a charge under the assault provisions of the Criminal Code.

Finally, if the woman has need of a safe place to go, be prepared to provide her with the information that will help her get to a local shelter. There are now over 265 such shelters in Canada and although they are concentrated in urban areas, more and more outlying regions are developing local networks of natural helping services to make other safe places available to women in rural areas.

In other than a crisis situation, it is more likely that the first interview around family violence would be initiated with some other presenting problem, such as depression, fatigue, or alcoholism in the family. In fact, workplace counsellors often miss the violence entirely in early contacts. As with all good counselling practices, allow the woman to talk. Be warm, accepting, and supportive. You may have a sense that what is going on beneath the story being told is another story of domestic violence. Realize that she is exploring, perhaps for the first time, the dawning of understanding about her victimization. Victims do not see themselves as victims. They protect the batterers, minimize what has happened to them, and describe ways that they could have "done it all better if only they had tried harder." Avoid expressing your own shock or disbelief and don't make judgments. Establish eye contact and ask, "Has anyone in your family ever hit you or threatened to hit you?" Encourage her to talk about the details of what has happened. This is important information for you, and it may also be the first opportunity that the woman has had to say out loud both for you and herself that she has been hit.

Many battered women are reluctant to leave their homes or their partners. You must explore the question of urgency with your client and discuss with her the dangers for the children in the home. If the situation does not appear urgent and she wishes to return home, help her map out a plan to get away in a crisis. She should have telephone numbers so that she can call for help. Provide the number of the local crisis line, the police, and the local shelter. She should keep aside money for a taxi or secure a set of car keys. She must think about how to take herself and the children out of the danger and into a safe place.

Having equipped the woman with the necessary information for getting out of a crisis situation, you must then consider the extent of your own involvement. Do you have the time, the experience, the interest to provide ongoing counselling? Probably, if it exists, community-based help for battered women should be a source of referral for any follow-up work. Depending upon the interests of the woman, it is possible that others can respond more effectively. Counsellors associated with battered women's shelters are the best informed and most experienced with this problem. If the woman is reluctant to associate herself with a shelter, you may refer her to a counsellor with a family services agency where she may be able to be served with continued confidentiality and at no personal cost. If you are unsure about the effectiveness of these

community services, you may want to monitor the situation closely or take on the whole counselling load yourself.

It is essential that counsellors who take on regular supportive counselling of battered women associate themselves with the community network of resources to understand the problem. Past responses of some counsellors have ranged from recommending marital counselling to advising that the woman leave the batterer immediately. Most responsible counsellors today do not recommend marital counselling unless there is absolutely no possibility that the man will continue to be violent and threaten the life of the woman. A woman who has been victimized in a marital relationship is not able to be an equal partner who feels free to talk during marital counselling. In the presence of her batterer, she will continue to feel intimidated or moved to defend his behavior. There are, of course, so many things to understand about the power imbalances that lead to violence, that EAP counsellors are well advised to link themselves to support networks.

In many communities there are inter-agency committees that would welcome your involvement and your experience from a workplace perspective. Such a committee may include battered women's advocates from the nearest shelter, a police officer, a social worker from a family services agency, a physician or nurse from the hospital, a member of the clergy, and a representative from the school board. Through the work of these committees, local guidelines are established so that everyone understands his or her role in helping battered women and children. Also in over 45 Canadian communities there are now counselling programs for battering men. Although these programs are still underfunded, are often full, and have not yet been evaluated to prove their effectiveness, you should investigate to decide if you could make a referral for a batterer.

PREPARING YOURSELF

There is no better way to begin further education about domestic violence than to attend conferences, workshops, and seminars. You can also learn much by reading (see appended reading list). For example, the following information about the woman's stages of realization about her victimization is based upon current counselling techniques (Sinclair, 1985).

Denial. Women often deny the extent and the degree of the violence. They minimize the assault and find ways to explain that what has happened is normal. The violence may have started out as pushing, shoving, and verbal abuse, but a slow escalation of the violence often breeds an acceptance of it. In 40% of first assaults, the women are pregnant, and the situations for them are much more complicated.

Self-Blame. As the violence continues, as the abuse persists, the women begin to be convinced of their own guilt. Their partners who accuse them of failure, inadequacy, or provocative behavior are their lovers, men they have believed and respected. The women become easily convinced that if they were better people or if they were to try harder, then the batterers would have no reason to lash out at them. Their self-confidence is dependent upon what the men as their mirrors tell them they are.

Seeking Help. When they try to speak to others, battered women hear too often that they must somehow have caused the problem. Unfortunately, the bystanders, who cannot understand, often give inappropriate messages out of their own fear or ignorance.

Going in and out of the Relationship. Counsellors often complain that battered women leave but return again to the relationship. This ambivalence on the part of the women leaves police angry. It is not unusual for women to leave three times before they finally decide to make their way alone. Sometimes, the women return, the violence stops, and then there is a recognition that the relationship should not continue; but, later, other reasons are accepted for terminating the relationship.

Why Do Battered Women Leave in the First Place? They fear for their lives and for the lives of their children. They hope they can support themselves alone. They leave to test their ability to survive as single women again.

Why Do Battered Women Return? They still love their men and they want the relationship to continue for themselves and the children. They believe the men's promises to reform. They feel guilty about breaking up the family. They cannot find the finances to survive alone. There is not sufficient housing, there are not enough jobs that pay well enough, and the supports do not exist. It is extremely difficult to be single sole-support mothers and to live in the constant fear that the batterers may eventually succeed in finding them and killing them.

During these phases, the Employee Assistance counsellor may

be the one ongoing contact for battered women. You may have to reach out into the community to do some brokerage for your client such as finding financial supports to enhance her income, assisting her in finding safe and affordable childcare, or directing her to community legal services. Within the workplace, you may help her deal with her superiors' frustration as she tries to get her life in order. Sole-support mothers often have to take time from work to tend to illness and upset in the lives of their children. They need to be away for court appearances or to visit lawyers. To the extent that you can, you will have to give her guidance in organizing such absences or in mediating conflict around them between the woman and her supervisor. If mediation fails with her direct supervisor, you may have to go higher in the organization to seek special leave until her situation normalizes or to assist with arranging a transfer to another part of the organization where she can have a fresh start.

Affirming Your Role as an EAP Counsellor

- Be convinced of the role that the workplace can play in preventing and intervening in domestic violence situations.
- Know that you are important in providing ongoing support, brokerage, mediation, and advocacy for battered women.
- Be prepared to convince the managers in your company of the importance of providing this type of counselling, for humanitarian and economic reasons.
- Seek out potential supports in the community, both for you and for battered women.
- Develop a file of education resources within your organization, such as films, books, and regular information sessions.
- Recognize that just as women have been undervalued in relationships in the workplace, your efforts to help battered women may be undervalued, misunderstood, and subject to criticism. You will need strength and determination if you are to see your commitment to these women through to a satisfactory situation. You will not be alone in feeling frustrated. Advocates for battered women commonly feel alone, frustrated, and burned out; but by helping each other, they can more successfully help the women and their children who are facing that violence directly. Build your own support network.

RESOURCES

INFORMATION CENTRES

Your local women's bookstore will have a good list of titles. Also remember to check with your public library. In addition, the following centres have access to information about wife assault and the other related issues of family violence that is available to you at reasonable cost.

The National Clearinghouse on Family Violence
7th Floor, Brooke Claxton Building
Health and Welfare Canada
Ottawa, ON K1A 1B5
Tel. (613) 957-2938

The Canadian Advisory Council on the Status of Women
Box 1541, Station B
Ottawa, ON K1P 5R5

YWCA of Canada
80 Gerrard Street East
Toronto, ON M5B 1G6
Tel. (416) 593-9886

In Ontario:

Ontario Women's Directorate
480 University Avenue, 2nd Floor
Toronto, ON M5G 1V2
Tel. (416) 597-4500

Education Wife Assault
427 Bloor Street West
Toronto, ON M5S 1X7
Tel. (416) 968-3422

In Manitoba:

Manitoba Committee on Wife Abuse
1823 1/2 Portage Avenue
Winnipeg, MB R3J 0G4

In Alberta:

Office for the Prevention of Family Violence
9th Floor, South Tower
10030 - 107 Street
Edmonton, AB T5J 3E4
Tel. (403) 427-7599

In British Columbia:

Women's Research Centre
301 - 2515 Burrard Street
Vancouver, BC V6J 3J6
Tel. (604) 734-0485

In the United States:

The National Coalition Against Domestic Violence
2401 Virginia Avenue NW
Suite 306
Washington, DC 20037
Tel. (202) 293-886

FILMS

The easiest access to films for public education in Canada is through the Family Violence Film Collection, which is financially supported by Health and Welfare Canada and managed by the National Film Board of Canada. Contact your nearest office of the NFB or write to:

National Film Board of Canada
150 Kent Street
Ottawa, ON K1A 0M9
Tel. (613) 996-4861

Book well in advance for the following films:

A Family Affair (NFB #106C 0181 169). 26 min., 16 mm, 1981. A battered woman calls the police when her husband tries again to kill her. She realizes that court action is the only way to stop the violence. The judge, in convicting and sentencing her husband, points out that assault is a criminal offence for which the batterer must bear the responsibility.

Loved, Honoured and Bruised (NFB #106C 0180 030). 25 min. 23 sec., 16 mm, 1980. Jeannie, a Manitoba housewife living in a rural area, left her husband because

he physically and mentally abused her. The film shows various stages in her escape from violence as Jeannie and her five daughters seek help from police and social workers.

The Next Step series: Sylvie's Story (NFB #106C 0186 504), *A Safe Distance* (NFB #106C 0186 505), *Moving On* (NFB #106C 0186 506). A parallel French-language series is also available (NFB #106C 0280-030). Three Canadian-made films document the issue of wife battering. *Sylvie's Story* tells of one woman's experiences in a shelter for battered women. *A Safe Distance* describes the special problems of rural and native women. *Moving On* examines the services needed by and available to battered women and the batterers.

No Place to Hide (NFB national office or CTV Network). VHS, 57 min. 57 sec. CTV Television Network Ltd. produced this moving 1985 documentary featuring Isabel Bassett. She talks to women, their husbands, and the children who are caught in the crossfire of wife assault. Legal and social options are explored.

The Rites of Violence (NFB #106C 0181-171). 28 min., 16 mm. This film features a story about a man who batters his wife and how the community intervenes. It is demonstrated that traditional attitudes that blame women for the battering can be changed into positive action to end the violence.

Shifting Gears (NFB #106C 0181 156). 13 min., 16 mm., 1981. A drama about wife battering shown from a man's perspective. Buddy, a former wife-beater, confronts his best friend and neighbor about the latter's abusive behavior.

To Have and to Hold (NFB #106C 0182 121). 20 min., 16 mm, 1982. Men who have used physical violence as a means of controlling or dominating their wives or lovers discuss the reasons for their behavior. Counselling leads them to come to terms with the reality of their unacceptable behavior.

Up the Creek (NFB #106C 0181 157). 15 min., 16 mm, 1981. A dramatization exploring the isolation and regret of a man who has battered his wife. Although she has left him, he continues to dismiss his violence as "just a little shoving and a few slaps."

We Will Not Be Beaten (NFB #106C 0181 155). 35 min., 16 mm, B&W, 1981. In an informal discussion at a women's shelter, battered women from all walks of life recount their experiences as victims.

Other NFB holdings include *Killing Us Softly: Advertising's Image of Women*; *Still Killing Us Softly*; and *In Need of Special Attention*.

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WOMEN AND CHEMICAL DEPENDENCE

ALCOHOL USE AMONG WOMEN IN CANADA

Florence Kellner Andrews and Irving Rootman

This chapter describes the drinking practices of a population sample of Canadian women over the age of 14. The sample on which it is based consists of 6,507 women, from all the provinces and Yukon.* The survey was conducted by telephone in June 1985** and had an 81% response rate. Items in the survey covered health-related attitudes and behaviors. Included were questions about the quantity and frequency of alcohol use. These questions make possible the assessment of variations in drinking patterns among Canadians. The analysis that follows consists of measures of women's alcohol consumption with some explanation of their variation by biosocial factors.†

Selecting only women for an analysis has the advantage of ensuring that women's drinking practices receive adequate scrutiny. Because alcohol consumption by men is so much greater, the drinking of women is often overshadowed in analysis when both genders are

* Data from the Northwest Territories were collected separately and are not included in this analysis.

** For more details on methodology and other survey findings, see Health and Welfare Canada, *Canada's Health Promotion Survey: Technical Report*, ed. Irving Rootman, Reg Warren, Thomas Stephens, and Larry Peters (Ottawa, Minister of Supply and Services, 1988).

† For a description of alcohol use for both sexes, see Chapter 4, "Alcohol Use," by Florence Andrews, in Health and Welfare Canada, *Canada's Health Promotion Survey: Technical Report*, pp 33-47.

included. Thus, some possible interesting variations in alcohol use, as well as some risk factors related to the use of alcohol by women, are less likely to be overlooked in a women-only sample.

DRINKING AND NON-DRINKING

The majority, or three-quarters (76.1%) of the women in Canada, are classified as current drinkers in this survey, having reported using alcohol at least once in the past 12 months. The proportions of former drinkers and lifelong abstainers are nearly equal, respectively comprising 12.9% and 11.1% of the sample.

TABLE 1

CURRENT DRINKERS AND NON-DRINKERS BY AGE GROUP

	Age group						
	15-19	20-24	25-34	35-44	45-54	55-64	65+
Drinker category	%	%	%	%	%	%	%
Current drinker	81.2	88.4	84.4	83.1	73.5	68.0	49.9
Former drinker	5.9	7.2	10.2	9.6	14.0	18.5	23.5
Lifelong abstainer	12.8	4.3	5.4	7.3	12.5	13.5	26.6

N = 6,492*

Whether or not a woman uses alcohol is related to her age. (See Table 1.) Women under 20 are slightly more likely than women in other age groups to have never used alcohol, but are still much more likely to be drinkers than to abstain from alcohol. With the exception of this very youngest group, the proportion of both lifelong abstainers and of former drinkers increases steadily with age, culminating in over a quarter of the women over 65 having never used alcohol. Counting former drinkers, half the women in this oldest category do not drink.

Women who use alcohol are more likely than women who do not

* Numbers used in the tables will differ from the 6,507 total because of cases that cannot be classified, usually because there is some information missing.

to be in the labor force. As for occupational categories, women working as administrators or professionals and those working in the clerical and sales fields constituted equal and high (88%) proportions of current drinkers. The proportion of current drinkers among manual workers is somewhat lower (80%).

Alcohol use, then, is a practice that is common among Canadian women. The relationship of the use of alcohol to age suggests an increase in the risk of alcohol-related problems in years to come: the more recent the age cohort, the greater the proportion of women who have had exposure to alcohol and the greater the proportion of alcohol users. Not all users are abusers, however. The following section describes those women whose volume of consumption may indicate some risk for alcohol problems.

SOME CHARACTERISTICS OF HIGH-VOLUME CONSUMERS

The 97 women who reported drinking over 21 drinks during the week prior to the survey were selected for special scrutiny. To put these women in context, consider the frequencies in Table 2.

TABLE 2

NUMBER OF ALCOHOLIC DRINKS DURING PREVIOUS WEEK

Number of drinks	*% of respondents*
No drinks (current drinkers)	35.8
1 to 5 drinks	25.1
6 to 10 drinks	9.3
11 to 15 drinks	2.5
16 to 20 drinks	1.2
21+ drinks	1.5
Not applicable (does not drink)	23.9
Not stated	.7

N = 6,507

Of the current drinkers, over a third reported no use of alcohol during that week. If this group is considered together with non-drinkers, we may conclude that a majority of Canadian women do not use alcohol on a regular basis. Moreover, of the current drinkers, the percentage of women decreased markedly with increases in reported number of drinks. Thus, descriptions of characteristics of heavy drinkers (21+ drinks) is based upon a very small minority of Canadian women.

By and large, the proportions of women who report this high consumption are spread across all the age groups according to their proportions in the sample, with an important exception: the 65+ age group contributes only half its proportion to the heavy drinker group. According to similar comparisons of proportions, marital status seems to make little difference in the propensity to drink heavily. Heavy consumption also seems to be unrelated to household size.

Heavy drinkers are more likely to be working than to be retired, in school, or looking for work. They are less likely to report "keeping house" as a main activity. If we consider just those in the labor force, professionals and administrators contribute less than their share in the sample to the heavy drinkers, and those doing manual labor contribute disproportionately more.

DRINKING PATTERNS AND CHARACTERISTICS OF CURRENT DRINKERS

When asked about the frequency of alcohol use during the past year, most of the current drinkers reported using alcohol less than once a week.* Table 3 shows the frequency of alcohol use according to the age of the respondent. Of current drinkers, the youngest and oldest groupings drink less frequently than do those between 20 and 54. During much of adulthood, then, around 40% of women who use alcohol report drinking as often as once a week.

* The reader may have noted a discrepancy between this statement and the discussion of data in the previous section. Most women reported drinking less than once a week when asked a general question about drinking frequency. When the question was more specific and queried alcohol use each day of the week prior to the survey, nearly two-thirds of women who drink reported having alcohol that week. There is general agreement among alcohol researchers that self-reports of volume of alcohol used are very often underestimations. However, the information remains useful, because it is valid in a relative sense: those who report they drink more, do indeed drink more than those who report drinking less.

TABLE 3

AGE OF CURRENT DRINKERS WHO USE ALCOHOL ONCE A WEEK OR MORE

Age group	*% of respondents*
15-19	27.6
20-24	43.0
25-34	39.5
35-44	40.9
45-54	44.7
55-64	35.4
65+	28.7

N = 4,927

According to the main activity of the respondents, those who use alcohol more frequently are likely to be in the labor force (Table 4). Among those in the labor force, the occupational category does appear to be associated with the frequency and the quantity of alcohol use (Tables 5 and 6). Administrators and professionals report drinking the least frequently. However, according to reports of their drinking activities during the week prior to the survey, administrators and professionals were the most likely to have had some alcohol (i.e., their frequencies are the lowest in the "no drinks" category).

DRINKING PRACTICES AND SELF-ASSESSMENT OF HEALTH

For the sample as a whole, current drinkers were more likely than former drinkers or lifelong abstainers to report that they were in excellent or very good health.* This relationship between drinking status and health assessment holds in all age groups with two exceptions. (See Table 7.)

TABLE 4

MAIN ACTIVITY OF THOSE WHO USE ALCOHOL AT LEAST ONCE A WEEK

Main activity	*% of respondents*
Working	46.5
Looking for work	38.8
Student	31.7
Retired	29.0
Keeping house	29.6

N = 4,852

TABLE 5

OCCUPATIONAL CATEGORY AND ALCOHOL USE AT LEAST ONCE A WEEK

*Occupational category**	*% who drink at least weekly*
Administrative/ professional	28.2
Clerical/sales	43.3
Manual labor	47.6

N = 2,386

* Those reporting working on a farm are not included in the tables that specify occupational categories, because the number is too small for a reliable estimate.

TABLE 6

NUMBER OF ALCOHOLIC DRINKS IN THE LAST 7 DAYS BY OCCUPATIONAL CATEGORY

	Occupation		
	Administrative/ professional	*Clerical/ sales*	*Manual labor*
Number of drinks	%	%	%
No drinks	36.3	41.4	42.7
1-10	55.7	50.6	45.4
11+	8.0	7.9	11.9

N = 2,384

TABLE 7

AGE GROUP, DRINKER STATUS, AND REPORT OF EXCELLENT OR VERY GOOD HEALTH

	Drinker status		
Age group	*Current drinker*	*Former drinker*	*Lifelong abstainer*
	%	%	%
15-19	61	50	68
20-24	64	50	53
25-34	71	61	63
35-44	70	58	64
45-54	68	54	50
55-64	55	38	46
65+	48	34	43
Totals	76	13	11

N = 6,483

* The item that measures health assessment is: "In general, compared with other persons your age, would you say your health is... (1. Excellent, 2. Very good, 3. Good, 4. Fair, 5. Poor)."

First, within all but the very youngest age group, current drinkers had the largest proportion reporting very good or excellent health, compared to others of their age. Among those 15 - 19, those who have never used alcohol report very good or excellent health in the greatest proportion. Second, except for women aged 45 - 54, former drinkers had the lowest proportions of those reporting superior health. It is possible, then, that cessation of alcohol use may have some relationship to health problems.

The relationship between drinking status and health assessment varies with occupational category. Administrators and professionals who are current drinkers and abstainers view themselves to be healthier than do those in other occupational categories. Among administrators and professionals, lifelong abstainers have the greatest proportion of those claiming superior health. In contrast, in the clerical/sales and manual labor groups, greater percentages of current drinkers than former drinkers or lifelong abstainers report excellent and very good health. (See Table 8.)

For current drinkers, a measure of the reported amount of alcohol consumed the previous week was cross-tabulated with health assessments for the sample of women as a whole and for the three occupational categories. (See Table 9.)

Among current drinkers, administrators and professionals reported excellent or very good health in the greatest proportions. However, the level of alcohol consumption is not strongly associated with an assessment of health in any of the three occupational groupings. Thus, while administrators and professionals have the best health assessments and manual laborers have the poorest, the amount of alcohol used has little relationship to self-reported health in any of these groups.

CONCLUSIONS

Insofar as alcohol use is concerned, this cross-sectional survey has some limitations regarding its ability to assess drinking practices that could threaten health. A population sample designed to represent the society will not include many people with characteristics that are rare in that society. It is also possible that respondents have underestimated the frequency and amount of their alcohol consumption.

Nevertheless, the findings of this analysis suggest that the misuse of alcohol is relatively rare among Canadian women. Despite the

TABLE 8

OCCUPATIONAL GROUP, DRINKER STATUS, AND REPORT OF EXCELLENT OR VERY GOOD HEALTH

	Drinker status		
Occupational group	*Current drinker*	*Former drinker*	*Lifelong abstainer*
	%	%	%
Administrative/ professional	75	64	81
Clerical/sales	69	65	64
Manual labor	65	60	56

N = 2,878

TABLE 9

OCCUPATIONAL GROUP, VOLUME OF ALCOHOL CONSUMED, AND REPORT OF EXCELLENT OR VERY GOOD HEALTH BY CURRENT DRINKERS

	Number of drinks the previous week		
Occupational group	*No drinks*	*10 drinks*	*11+ drinks*
	%	%	%
All current drinkers	60	68	64
Administrative/professional	74	76	76
Clerical/sales	68	70	73
Manual labor	64	65	61

N = 2,381

fact that the decades since the Second World War have witnessed an increase in women's exposure to alcohol (i.e., the proportion of lifelong abstainers is lowest in more recent adult birth cohorts), there seems to be no increase in drinking behaviors associated with health risks. This is not to say that alcohol problems among women are negligible or are unimportant. Rather, what this survey indicates is a general propensity for women to use alcohol in very moderate amounts, with little indication that the *proportion* of women drinkers having problems with alcohol will increase. However, it is very likely that the next few decades will see an elevation in the total *numbers* of problem drinkers. Given that there are fewer abstainers in younger age groups as well as generally greater longevity, there is a probability of an increase of alcohol-related problems and a need for increased attention to resources and rehabilitative facilities dedicated to such problems.

This analysis suggests that a very small percentage of women are at risk of drinking-related damage,* and it does not support media-based messages about the ubiquity of the alcoholic housewife whose drinking problem is hidden at home. Rather, the woman who uses alcohol and who has problems with it is more likely to be in the labor force and is somewhat more likely to work in manual labor. Because most alcoholics are able to hide their affliction for quite some time and because women are even more motivated to conceal drinking problems than men are, alcoholism can be hidden in the workplace as well as in the household. The proportion of women in the labor force has increased swiftly and steadily during the past four decades, and so has the proportion of women exposed to alcohol during this time span. Both of these trends point to a necessity for having support and rehabilitative systems on site in the workplace that can deal with alcohol dependence among women.

While the responses to a health assessment question may include substantial overestimation regarding level of health, it is encouraging to see that the majority of women judge themselves to be in excellent or very good health. For the female population as a whole, current drinkers tended to report very good health in greater proportions than either former drinkers or lifelong abstainers. According to the present analysis, only two categories of lifelong abstainers reported superior health in greater proportions than did drinkers: those between

* We used the criterion of having had 21 or more drinks the previous week.

15 and 19, and those in the administrative/professional occupational category. It is quite likely that the 15 - 19 age group will begin to use alcohol—that both their abstinence and their reports of good health can be explained by their youth. It is, however, difficult to interpret the health assessment of the lifelong abstainers in the professional category.*

There is some cause for concern about the lower levels of good health assessment in the clerical and the manual labor groups, as compared to the administrative and professional groups. Workplaces that involve health services should account for the possibility of occupational differential in needs for these services. Among women of a given occupational category, the volume of alcohol used does not appear to have any relationship to the assessment of their health.

Overall, complete abstinence from alcohol is becoming less common. However, the normative pattern of drinking for women in Canada is that of considerable moderation. This general pattern is useful as a backdrop against which to assess deviations from norms. On the one hand, there is reason to be optimistic, because of the generally temperate use of alcohol by women. On the other hand, those women who misuse alcohol need extensive help: they are part of a numerical minority and are surely part of a normative one as well.

* There is a strong possibility that the higher percentage of lifelong abstainers in this category could be an artifact of the very small number of administrative or professional women who abstain from alcohol to begin with. Among the women who occupy this work category, 924 were current drinkers, 77 former drinkers, and only 47 lifelong abstainers.

IDENTIFICATION, ASSESSMENT, AND REFERRAL OF CHEMICALLY DEPENDENT WOMEN IN THE WORKPLACE:
Facilitating the Process

LYNN O. LIGHTFOOT

Intervening to help troubled employees is a multifaceted task that presents a number of challenges to all of those involved in the implementation of Employee Assistance Programs (EAPs) at the worksite. The focus in this chapter will be to demonstrate that effective intervention with female employees requires an additional understanding and appreciation of the unique characteristics and needs of women experiencing alcohol, drug, and related problems. These unique characteristics and needs will be identified, and the implications for modifications to each phase of the intervention process, including identification, assessment, and referral to treatment, will be described. It will be argued that EAP planners and implementors must become sensitive to and skilled in addressing these issues in policy and in programming, if women are to be effectively served by EAPs.

THE CHALLENGE

How can we identify women in the workplace who are experiencing alcohol and/or drug and related problems? Are there reliable

signs, symptoms, behaviors that should alert the supervisor or the occupational health nurse or other identified intervenor to the possibility of a substance abuse problem? If we do suspect a problem, how do we respond in a constructive and helpful way? How do we determine if there really is a problem? What does a good alcohol and drug assessment include? What kinds of treatment or intervention are available, which ones are effective, and how do we decide which is the most appropriate for this particular woman? How do we make a referral, and how can we help and support the employee in her attempts to make changes? These questions are ones that confront and often confound all of those individuals who are involved in EAPs.

WHY IDENTIFY?

Before considering the "how" of problem employee identification, it is important first of all to reconsider the "why" of identification. Without a commitment to the importance and desirability of identification and intervention, all the knowledge in the world will not result in active participation in identification by designated individuals in the workplace. That this is a concern is made obvious by the low participation rate of women compared to men in current EAPs (Beyer & Trice, 1981).

There are a number of compelling reasons why women with substance abuse or dependency problems should be identified in the worksite and encouraged to seek help. From a broad societal perspective, there are enormous economic and social costs associated with substance abuse and dependence including lost productivity and increased morbidity and mortality (Hill, 1984). The health and social risks and costs to families and others have been specifically addressed in other chapters of this book and elsewhere (Williams & Klerman, 1984). From a purely humanitarian perspective, the personal costs, including loss of self-esteem, guilt, and shame, decreased quality of life, and reduced life expectancy, provide ample justification for the identification of women with problems.

Another extremely important rationale for early identification at the worksite is that prognosis following intervention is more favorable when it occurs at earlier stages in the course of substance dependence (Berg & Skutle, 1986; Miller & Hester, 1986). Although there has been a tendency for courts and worksites to protect women from the immediate short-term consequences of substance abuse (e.g., embarrassment

and stigma associated with labelling and mandatory referral to treatment), by overlooking or ignoring possible alcohol/drug abuse, this course must be weighed against the potentially much more severe long-term consequences of substance dependence: job loss, accidental death or injury, physical and emotional ill health, intellectual impairment and loss, and suicide (Hill, 1984). Worksites, because of their daily involvement with women employees, are in an excellent position to identify problems that might otherwise go undetected for years and might eventually seriously jeopardize the woman's health and well-being. It is important to note that women working outside the home are more likely to be drinkers (Alcohol & Health, 1971; Health & Welfare Canada, 1981) than women working in the home. There is also some evidence that married women working outside the home have significantly higher rates of problem drinking than housewives (Johnson, 1982). With the constantly expanding role of women in the workplace comes an increased opportunity for effective early intervention.

WHAT ARE WE IDENTIFYING?

In order to identify and intervene appropriately with women who evidence problems, it is essential that we define our terms carefully. What do we mean when we use the terms "substance abuse" and "substance dependence"?

Approximately 85% of North Americans drink alcohol (Cahalan, Cisin, & Crossley, 1968). The majority do so without problems. Some individuals, approximately 5% of adult males and 3% of adult females, have major symptoms of physical and psychological dependence on alcohol. These symptoms include impaired control over drinking, significant withdrawal symptoms upon cessation of drinking, and an obsessive-compulsive drinking style (American Psychiatric Association, DSM III-R, 1987). These individuals are the ones most frequently referred to as "alcoholics." Similarly we use the term "drug addict" when the substance of choice is another mood-modifying drug.

There is, in addition to these two groups, another group who do not show major symptoms of physical dependence but who use substances in circumstances or at levels that increase their risks of physical, social, or psychological consequences. These individuals, approximately 20% of men and 7% to 9% of women, are typically referred to as substance abusers. These are the targets for early identification and intervention programs.

HOW DO WE IDENTIFY SUBSTANCE ABUSE PROBLEMS AT THE WORKSITE?

At the outset, it is important to acknowledge that there are no specific physical or behavioral signs and symptoms, or laboratory or clinical tests, that are one hundred percent sensitive and reliable in the identification of substance abuse problems (Skinner, Holt, Sheu, & Israel, 1981; Skinner, Holt, Sheu, & Israel, 1986). Although much is said about the size of pupils being indicative of particular drugs of abuse, for example, most experts agree that it is only through the observation of a number of convergent indicators, which include behaviors and physical and emotional signs and symptoms, that the increased probability of substance abuse or dependence is suggested. The greater the number of associated signs and symptoms, the greater the probability of a problem.

Most EAP training programs identify the following as possible early indicators of substance abuse problems: increased absenteeism (particularly Mondays and Fridays); tardiness in returning to work from lunch and breaks; moodiness (emotional lability) and irritability with others; evidence of intoxication or substance use in the workplace; increased rates of accidents and injuries (both at the worksite and outside); alcohol on the breath; red eyes, nose, and face; reduced productivity; problems with concentration and memory; reports or evidence of family, legal, or financial problems; and sleep disturbances.

There is little information available, however, that indicates which of these behaviors/signs are more likely to be observed in women than in men. Although there is evidence of considerable overlap (Ferrence, 1980), additional signs that may be important for women may include frequent absences from work for medical services (e.g., frequent doctor appointments, illnesses), evidence of depression (lethargy, generally slowed activity, crying, significant weight loss/gain, decreased ability to make decisions), and family or social problems.

Although specific identification of an alcohol or drug problem cannot be made with this level and type of information, any employee demonstrating two, three, or more of these behaviors or symptoms over three or four weeks should be encouraged to have a consultation with a health professional. A direct, non-judgmental statement from the supervisor or other designated intervenor describing the nature and extent of the performance problem (behavior and output), and followed by the specification of the required performance standard, can be used to facilitate the referral recommendation. It should be noted at this point

that women are more likely to self-refer than men. However, women usually seek help for different problems. Women are more likely to seek help for family and social problems (Brodzinski & Goyer, 1987) than for alcohol problems, and are more likely to seek help from a medical or social service agency than from an addictions treatment agency.

SCREENING INSTRUMENTS

A variety of screening instruments have been developed to assist in the identification of substance abuse problems. Skinner and associates (Skinner & Holt, 1986) have, for example, developed the Alcohol Clinical Index for identification of alcohol problems in health care settings. This instrument was derived from an analysis of 108 clinical and laboratory tests that were considered potential indicators of alcohol abuse. It comprises two parts. The first part consists of 17 clinical signs that should be looked for by the physician or nurse practitioner as part of a general physical examination. The second part consists of 13 yes/no medical history items that can be either self-reported by the patient or completed as part of an interview. With this instrument, as with all the others we will consider in this section, despite the evidence that women appear to be more vulnerable to the health consequences of alcohol (Hill, 1984), recommended cut-off points are not differentiated for men and women.

Skinner and Holt (1986) identify three laboratory tests that can be used to corroborate a diagnosis of alcohol abuse: elevated serum gamma-glutamyl-transferase (GGT); macrocytosis without anemia; and random blood alcohol concentration of >80 mg/dL. Skinner et al. provide no information, however, that indicates if these tests have comparable sensitivity and specificity in males and females. GGT is also affected by other hepatic-enzyme-inducing drugs; and given the increased probability of multiple dependence in women, GGT may be less specific but more sensitive to substance dependence in women.

The CAGE (Ewing, 1984) is a very brief (four-item) questionnaire that assesses the personal recognition of a drinking problem. The four items are: Do you feel a need to cut down on your drinking? Are you annoyed by criticism of your drinking? Do you feel guilty about drinking? and Do you ever drink first thing in the morning? Two or more affirmative responses on the CAGE indicate personal recognition of a drinking problem.

Despite its brevity, in a comparison with laboratory tests the

CAGE identified 90% of alcoholics, whereas laboratory tests identified only 33%. Once again, however, we do not know if this instrument is equally sensitive and specific for males and females. Given the evidence that women are more sensitive about their drinking than men (Horn & Wanberg, 1970), the first three items may be highly relevant for women. However, given the lower average consumption of female problem drinkers, the fourth item may not be as discriminating for women as it is for men, and a modified cut-off score (one item) may be more appropriate in screening women for alcohol problems.

Other brief screening instruments that merit some attention here are the Short Michigan Alcoholism Screening Test (SMAST; Selzer, 1975) and the Drug Abuse Screening Test (DAST; Skinner, 1982). The SMAST, a shortened version (13 items) of the MAST, identifies social, psychological, and physical consequences of alcohol use. The DAST is a brief self-report questionnaire designed to assess the degree of dependence on drugs (prescribed, over-the counter, and non-medical) other than alcohol. Although both instruments are widely used and have good psychometric properties, validation data on women are very limited.

The final questionnaire that we will consider in this section is the Alcohol Dependence Scale (ADS; Skinner & Horn, 1984). This instrument provides a brief (25 self-report items) measure of the extent to which the use of alcohol has progressed from psychological involvement to impaired control. It was derived from a longer multi-scale assessment instrument, the Alcohol Use Inventory (Horn, Wanberg, & Foster, 1983), and finds its theoretical base in the alcohol dependence syndrome as described by the World Health Organization (Edwards & Gross, 1976; Edwards, Gross, Keller, Moser, & Room, 1977). Although the ADS has good reliability and validity properties, and normative data are available from various outpatient and inpatient samples, no separate normative data for women have been developed. Wanberg and Horn (1970), authors of the original instrument from which the ADS was derived, have observed that although women report the same range of alcohol-related symptoms and problems as men, the severity of their responses is significantly lower than among men. Wanberg and Horn's analysis suggests that separate normative data for men and women should be developed. Clearly worksites that choose to utilize screening instruments would be well advised to develop separate normative profiles for their men and women employees. In the meantime recom-

mended cut-off scores for all the screening instruments described above, which were validated on male samples, should be viewed with caution.

CONDUCTING "GOOD" ALCOHOL AND DRUG ASSESSMENTS

Screening is a procedure to identify individuals for whom a comprehensive assessment is appropriate. Assessment is a process designed to yield a broad and comprehensive base of valid and reliable information about a woman, from which an appropriate and maximally effective treatment plan can be developed. Clearly it is beyond the scope of this paper to describe in detail the process involved and the content to be covered in the conduct of alcohol and drug assessments with women. It is possible, however, to identify the key elements that should be addressed in an initial assessment. (For a more extensive treatment of this subject the reader is referred to an excellent chapter by Braiker, 1984.)

It is important to acknowledge at the outset that the population of women with alcohol and drug problems is heterogeneous. Schuckit and associates (Schuckit, Pitts, Reich, King, & Winokur, 1969) have, for example, identified two major clinical categories: primary alcoholics (i.e., those with no pre-existing major psychiatric disorder) and secondary alcoholics (i.e., those who evidence primary psychiatric disorder with alcoholism as a secondary problem). Within the secondary alcoholic type, Schuckit and Morrisey (1976) further identify two categories: affective disorder alcoholics and sociopathic alcoholics. In the former type, a primary affective disorder (depression) antedates the alcohol disorder, and in the latter, antisocial behavior antedates the alcohol disorder. In addition, Beckman (1976) and others (Ferrence & Whitehead, 1980) have noted that women are more likely than men to abuse more than one substance, and it is important for treatment planning purposes to distinguish these women from those who abuse only alcohol.

A comprehensive assessment should assess the following content areas: the amount, frequency, and pattern of use of all substances currently used by the client (i.e., alcohol and other drugs); the nature and extent of alcohol- or drug-related social, physical, and psychological disabilities; the immediate consequences and risks of the abuse (e.g., driving while impaired); the environmental, affective, and cognitive antecedents of alcohol or drug use; previous history of treatment for substance abuse or emotional difficulties; and the nature and extent of personal and social supports. In addition, if the client is of childbearing

age and sexually active, her current birth control practices should be examined, and information about the effect on a fetus of the substance being abused should be provided.

It is important to note that serious negative consequences of drinking are less frequently observed in women than in men, possibly as a result of women's lower visibility or their differential treatment by police and the courts. Family and emotional health problems may be more frequently linked to substance use by women than by men. It is also important to note that on average, women alcoholics drink less than men do, and that absolute consumption levels have different meanings for males and females. The difference may in part be due to the fact that women, because of their higher fat/fluid ratio, reach higher blood alcohol concentrations than men, given equal doses of alcohol and equal body weight. Given the research evidence suggesting that women may be more prone to physical damage from excessive drinking, a threshold of three standard drinks per day (i.e., of $1^1/_2$ ounces of spirits, or equivalent) has been denoted as "at risk" level of drinking for women (Skinner & Holt, 1986).

The assessment process should conclude with a discussion of treatment goals. Most of the research on the relative effectiveness of abstinence versus moderated drinking as goals has been conducted with male clients. If we can extrapolate from these findings, however, the following generalizations are suggested for women. Depending upon the nature and extent of substance dependence, and the preferences of the client, treatment goals may include abstention or social drinking. Younger women with low levels of dependence may have better outcomes if they participate in a program of modified drinking rather than abstention. On the other hand, older women (over 40) with high levels of dependence on alcohol and a number of alcohol-related disabilities may have better outcomes with abstinence as the goal. (For a more thorough discussion of this issue, see Miller & Heather, 1986.) There is some evidence that women may be more successful with moderated drinking programs than men (Taylor, Helzer, & Robins, 1986). Other targeted goals of treatment may include education, work, family, marriage, personal skills (e.g., assertion, social skills).

Braiker (1984) recommends the use of a structured interview in substance abuse assessment in order to increase the reliability and validity of the elicited information. She notes that assessment information is useful not only for diagnostic purposes but also for providing

baseline information against which improvement or change can be measured. According to Braiker (1984),

> while several purposes are served, perhaps the most important is that the comprehensive clinical assessment conveys the sense that the patient is being viewed and accepted as a whole person, not merely as "an alcoholic" and that her drinking problems are embedded in a complex matrix of the social, emotional, and physiological facts of her life. (p. 261)

MOTIVATIONAL INTERVIEWING

Thus far our discussion of the screening and assessment process has addressed primarily the content issue—that is, what specific information should be sought in the assessment interview. An equally, if not more, important aspect of intervention concerns the way in which information is solicited from the employee, and the way she is engaged in the entire intervention process. Miller (1983), after reviewing the literature on motivation, posed some provocative recommendations about the manner in which screening and assessment of alcohol and drug dependence should be conducted. He describes "Motivational Interviewing" as an alternative to the traditional confrontational model of interviewing typically used with substance-abusing clients. It is an approach that is based on the principles of social psychology, in which motivation is seen as an interpersonal process instead of an enduring personality trait. In this model there is a de-emphasis on labelling and a focus on individual responsibility and internal attribution of change.

Despite beliefs to the contrary, Miller has demonstrated that denial as a defence mechanism is no more or less characteristic of alcoholics than of other people when objective personality assessment findings are examined. Instead, Miller paints the picture of the substance abuser as an individual who is in conflict; on the one hand she is concerned about her drinking, and on the other she enjoys drinking and doesn't want to stop. Social psychological research predicts that the counsellor who takes the position that the client is an alcoholic or drug addict and must stop immediately and forever will in essence "force" the client to argue the opposite position. To avoid this no-win situation, Miller recommends that the counsellor employ the empathetic client-centred style of Carl Rogers, combined with the non-judgmental feedback of objective assessment data, to increase the client's awareness of the negative consequences of drinking/drug use. Provision of information in this way will create a state of dissonance between what the client

is doing (drinking) and the awareness of its negative consequences. This state of dissonance creates a motivational state that the skilful therapist must then channel towards behavior change (reduction or abstinence). The intervenor can build on this motivational state by acknowledging that although change may be difficult, it is possible. Breaking down the change process into small concrete steps, which the woman feels are realistic and achievable, is a strategy that intervenors can use to support her motivation for and active participation in changing her behavior.

TREATMENT: WHAT WORKS BEST FOR WOMEN?

There is a bewildering array of alcohol and drug abuse treatment programs, which vary tremendously in terms of their theoretical orientation (e.g., cognitive versus behavioral versus psychodynamic), their location (hospital or other institution versus community), and their intensity and duration (residential versus day versus outpatient treatment). Do some modalities of treatment work better for women than others? Many have speculated, for example, that women will do better with women therapists, in women-only treatment programs. Unfortunately there is very little hard scientific evidence to help make informed choices about treatment for women. Reviews of the literature indicate that few studies have systematically addressed the question of gender differences in treatment outcome. The few studies that have been done do not suggest any systematic differences between outcome rates for men and women (Annis & Liban, 1980; Vannicelli, 1984). If we look to reviews on the effectiveness of alcoholism treatment for men for guidance, the following general conclusions may be helpful to treatment planners and providers.

First, there is little empirical evidence to suggest that longer, more intensive treatment is necessarily more effective than brief treatment (Miller & Hester, 1986). It may be the case, however, that women who are more severely dependent, who have limited social support, and who have a long history (10+ years) of problematic substance use will require lengthier, more intensive treatments. In general, however, women who are employed and who evidence moderate social stability are as likely to benefit from outpatient/day treatment programs as they would from a residential treatment program. Many clinicians are recommending that, as a general rule, treatment should begin with the least intrusive intervention possible (i.e., brief interventions). If, with continuing monitoring of the case, this level of treatment proves ineffective, only then should more intrusive interventions be tried.

Research has also indicated that when clients are actively involved in the planning of their own treatment, both compliance with and effectiveness of treatment are enhanced (Ewing, 1977; Miller & Hester, 1986b; Sanchez-Craig,1980). In the absence of sound empirical data to guide decisions about treatment, the best short-term solution may be to provide women with information about the treatment/intervention alternatives that are open to them and let them make an informed choice of the most appropriate course of action for themselves.

GETTING WOMEN INTO TREATMENT: BARRIERS TO TREATMENT INVOLVEMENT FOR WOMEN

Although there is considerable evidence that in general alcohol/drug treatment is effective, women experience more barriers to involvement in treatment than men. Friends and spouses are, for example, more likely to oppose involvement in treatment for women than they are for men. Health care providers are more likely to misdiagnose or entirely overlook alcohol problems in women than in men. The absence of important support services such as childcare, counselling for battered women and incest survivors, treatment for prescription drug abuse, and medical and nutritional counselling have all been identified as potential barriers to alcohol/drug treatment involvement by women (Beckman & Amaro, 1984). Clearly if EAPs for women are to be effective, treatment providers must address the particular support and adjunctive service needs of women. If they do not, there will be a substantial dropout rate between identification and treatment completion.

AFTERCARE

There has been a general tendency to consider treatment as the end point of the intervention process. It may be more appropriate, however, to consider treatment to be the beginning of the behavior change process rather than the end. Considerable evidence is accumulating that indicates that what happens after treatment can be as important as treatment itself, if not more important to the eventual outcome (Berg & Skuttle, 1986). For this reason participation in an aftercare program should be actively encouraged by EAPs. Aftercare programs can provide emotional support, relapse prevention training, and crisis intervention services to women following completion of active treatment. In this way the gains made in treatment can be consolidated and built upon, and the probability of a positive long-term outcome increased.

SUMMARY AND CONCLUSIONS

This chapter has focused on identification, assessment, and referral of troubled women in the workplace. A review of available screening instruments indicates that most have been developed and validated with men, and that cut-off scores for women may need to be modified if the instruments are to be effective in identifying women with alcohol and drug problems. The key components of a comprehensive alcohol/drug assessment are described, with note made of those areas that are more salient for women than men and which may be essential to effective treatment planning. Motivational interviewing was described as an alternative model for facilitating the identification of a problem by the employee and for enhancing motivation for treatment.

Although there are a variety of treatment options available, which vary in terms of location, duration, intensity, and theoretical rationale, there is little empirical evidence available to indicate which types of treatment are most effective for which women. In general, shorter treatments are recommended, and there is some evidence that controlled drinking programs may be more effective for women than for men. Active involvement of women in the treatment planning process was identified as a means of increasing treatment effectiveness and compliance. Aftercare programs were described as an essential component of the intervention process that should be encouraged and supported by EAPs.

Finally, of particular relevance for women is the provision of support and adjunctive treatment services. Primary here is provision of childcare and family, marital, and individual counselling for victims of incest and assault.

In conclusion, if EAPs hope to increase the traditionally low utilization rates of women, EAP programs and the treatment providers they contract with must address the unique characteristics and needs of women.

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PROGRAMS FOR CHEMICALLY DEPENDENT WOMEN

COLLEEN LUNDY

The increasing participation of women in all segments of society, and the political implications that this holds, has sparked new interest in all aspects of their lives including their alcohol and drug dependence. One result of renewed interest is that widely held perceptions about women's drinking are being challenged. For example, the view that women drink less often, in smaller quantities, and less publicly than men is being countered by research that reports young female workers with higher rates of heavy drinking than their male counterparts (Whitehead & Layne, 1987). Also, although alcohol is the primary substance problem, especially in the workplace (Report of the National Consultation, 1988), women are found to be more likely than men to be taking prescribed mood-modifying pills or to have a dual addiction (Aldoory, 1978; Gomberg, 1986).

The purpose of this chapter is to sketch the development of alcohol and drug treatment programs and services for chemically dependent women. It also includes a critique of the premises upon which these programs are based and the general approach to women's chemical dependence taken by the professional community. In particular, it will suggest ways in which these programs can better assist alcohol- and drug-dependent women.

MALE-CENTRED MAINSTREAM PROGRAMS

Since it is only in the last several decades that the widespread abuse of alcohol and drugs by women has been acknowledged, it is not surprising that the first treatment programs were developed for men. However, this tradition continues today, and programs that serve both men and women often reflect the experiences and needs of the former. This bias is well illustrated by the fact that women are hardly even represented in studies on program effectiveness. Vannicelli (1984), in compiling the results of program evaluation studies conducted over a 30-year period, showed that in the 20-year period from 1952 to 1972, women comprised only 6.2% of the people studied in 271 treatment programs, and for the period from 1972 to 1980 (a time when chemical dependence in women was becoming more visible) only 7.8% of those studied in such programs were women.

As well as being male centred, programs for chemical dependence have been and continue to be, for the most part, inspired by perspectives that view alcohol and drug dependence as a disease or deficiency lodged within the individual. In terms of the help provided, the emphasis is on counselling that promotes an acceptance of one's affliction, a commitment to lifelong abstinence, and a desire for personal/lifestyle change.

Existing programs and services fall into six general categories. They are: assessment and referral services, which offer general information and assessment of chemical use; detoxication, which provides short-term non-medical or medical care during withdrawal from alcohol and other drugs; institutionally based programs, which usually involve 28-day inpatient treatment programs and outpatient aftercare; day/outpatient treatment programs, which offer a structured format for recovery; supportive residences, which provide women with accommodation for up to a year and also have a structured recovery program; and self-help programs of an informal non-professional nature such as Alcoholics Anonymous and lesser-known support groups such as Women for Sobriety.

The components of these programs vary but generally offer a combination of the following: individual counselling, family involvement, an intensive group experience, educational sessions, stress reduction and relaxation exercises, psychological evaluation, recreational activities, and social skills training. There is no indication that the more costly inpatient programs are more effective than the non-residential

programs. The comparative effectiveness of these programs is still an unresolved debate; but Miller and Hester (1986), in their review of the findings from 26 controlled comparison studies of residential and non-residential programs, concluded that in no case did residential care yield superior results to the less expensive treatment alternatives such as outpatient/day programs. As with so many other studies, these do not identify the sex of the participants, and the findings may once again be speaking mainly to the experience of men in treatment programs.

Only in the last decade has it been recognized that the context of women's alcohol and other drug use and their program needs are different from those of men, and this recognition articulated and acted on by the helping professions. Although there has been a striking increase in the extent of services available to the chemically dependent population in general, the most significant developments in the past decade have been in the area of services solely for women. Although many women seeking help may still be faced with a program that is predominantly male-client and male-worker dominated, increasingly there is the option of an all-women's service. In addition, a number of the more traditional programs have introduced women's groups, as for example when Alcoholics Anonymous guidelines were recently changed to accommodate the formation and operation of meetings just for women.

DEPENDENCY AND WOMEN'S EXPERIENCES

Recent research based on a feminist or women-centred analysis has looked to the social context of women's lives to understand alcohol and pill use (Nichols, 1985). Such analysis has produced a very different understanding of women's dependency and how we might help them.

It must be realized that how we help chemically dependent women is very much a function of how we perceive them and how we theorize about their problems. First of all it must be stressed that most female research subjects, including those of the feminist-inspired research, are white middle-class (or class unspecified) urban women. We know little about drinking among women who are poor, non-white, and rural, and we know even less about the elderly, lesbian, or other sectors of the female population.

With this caveat in mind we can say that much of the recent research suggests that chemical dependence for women is strongly connected to political, economic, and social factors in their lives as

opposed to psychological ones. Even the most sophisticated deficiency-oriented psychological theories—such as the view that women's roles and their perceptions about those roles are driving them to drink—are being questioned. One of the premises of the role conflict theory is that alcoholic women are struggling with role conflicts, sex-role identification, and confusion about their femininity (Wilsnack, 1973), thus emphasizing intra-psychic conflict and adjustment while failing to deal adequately with the material conditions of women's lives and their social relationships (Lundy, 1987). A closer look at women's lived experience demonstrates how femininity and women's roles are socially constructed and in particular how patriarchal and class systems limit the opportunities for women and keep them subordinate to men.

A striking feature of chemically dependent women, as portrayed in the recent research findings, is the alienation, isolation, and powerlessness they experience. Women's drinking, according to Marian Sandmaier (1980), relates to the social situation they face.

> Every dimension of a woman's addiction—its causes, its consequences, its subversive hidden quality, its treatment—[is] shaped by her subordinate and devalued status. To a large degree, the depth of this connection stems from the sheer pervasiveness of sexism. Women are driven to all kinds of self-destructive escapes from their powerlessness and their conflicted visions of themselves: depression, compulsive eating, other drug addiction, obsessive housekeeping, suicide...Alcohol is only one escape among many. (p. 32)

That the woman alcoholic is then viewed as "psychologically sicker" than her male counterpart adds insult to injury. The belief that women exhibit more psychopathology and maladjustment than men is primarily based on findings that women alcoholics show more history of mental illness, suicide attempts, broken marriages, and affective disorders such as depression (Curlee, 1970; Rathod & Thomson, 1971; Wilsnack, 1973). Even if true, the untenable explanation of such phenomena shows an ignorance of women's position in society and a misunderstanding of how such disorders and problems relate to it.

There is no doubt that depression is a particular problem for women, and it is a well-known fact that women are twice as likely to attempt suicide (*Women and Mental Health in Canada*, 1987). It is, however, the source of depression that is well hidden and unexplored, especially in regard to alcohol-dependent women. Chemical abuse in women is closely related to depression, which in turn seems closely tied

to the generally oppressive conditions of women (Nichols, 1985). Gender inequality, which is characterized by lower wages, higher unemployment, more welfare, frequent dependence on a spouse, isolation within the home, and limited opportunities outside the home, are the major sources of depression for most women. It is no wonder then that women alcoholics report drinking to escape feelings of powerlessness, inadequacy, and low self-esteem (Beckman, 1978, 1980).

WOMEN AND THE FAMILY

Alcohol-dependent women are often alone without the support of family or friends and are more likely than men to be without a partner when they enter treatment (Curlee, 1970; Gomberg, 1976). One study showed that although 9 out of 10 women remain with their alcoholic husbands, 9 out of 10 men leave their alcoholic wives (Fraser, 1973); moreover, the married female alcoholic usually faces a partner's refusal to participate in either family counselling or support groups such as Alanon (Lindbeck, 1972). Alcohol-dependent women often report poor relationships with their partners (Mulford, 1977; Schilit & Gomberg, 1987), who may very well be alcohol dependent themselves (Hoffman & Noem, 1975). It is also reported that when they recognize their problem and seek help, opposition from partners, family, and friends is not uncommon (Beckman & Amaro, 1986). For younger drinking women, social support systems appear even less adequate. They report fewer friends and relatives to whom they can turn for help and have more stressful relationships than middle-aged alcoholic women; thus they are in an especially vulnerable position (Schilit & Gomberg, 1987).

As well as neglect, there is often a history of a disturbing amount of violence in the childhood and adolescent years of female alcoholics (Beckman, 1984; Covington & Kohen, 1984; Lundy, 1985). In my own research I interviewed 50 alcoholic women and found that 76% had been the victims of either physical, sexual, or emotional abuse from their parents. Physical abuse occurred among 42% of the women; and 36% reported a daughter-father/stepfather relationship that included at least one episode of sexual abuse involving acts from fondling to forcible entry. Other researchers have also found high incest rates of 14.9% (Beckman, 1984) and 34% (Covington & Kohen, 1984). Although there are no precise and reliable figures on the incidence of father-daughter incest in the general population, there are estimates (conservative in my view) that 4% of females are so violated (Russell, 1986). The research also shows that violence follows many women into their adult lives, where

they are beaten and sexually assaulted by their spouse. In one study 40.4% of the alcoholic women reported having been sexually molested or raped as an adult, and 56% reported physical abuse by their partner or someone close to them (Beckman, 1984).

WOMEN AND WORK

As with the family, women also find that they confront a difficult situation in the paid workforce. Although women comprise 42% of wage workers, they are highly concentrated in jobs that are characterized as "women's work," such as clerical, service, health care, and elementary and secondary school teaching (*Women & Mental Health in Canada*, 1987). Women also have less job security, permanence, and benefits, and earn only 64% of what is earned by men. Very important is the fact that women who work outside the home have two jobs: the many and demanding aspects of women's labor in the home can be all-consuming for the women involved, but it goes unrecognized by family and society (Strong-Boag, 1986).

Until very recently researchers have largely neglected the study of chemically dependent women in relation to their work. Although contradictory in some respects, the available findings suggest that the nature and circumstances of women's work is a significant factor in excessive alcohol use. Married women with jobs or long-term unemployed women who are still seeking work report higher rates of problem drinking than either single working women or housewives who have not been in the job market (Johnson, 1982). Furthermore, a lack of employment or financial means creates barriers for women who seek help (Beckman & Amaro, 1984).

DIRECTIONS FOR HELPING

Although much more investigation is required into the problems discussed above, it is clear that the social conditions women face and the nature and quality of their social relationships influence not only the onset and progression of dependence, but also their opportunities for recovery and entry into a treatment program. That is why the structure and approach of the helping agencies are important factors in attracting women and encouraging them to enter a program. It has been found that of those women who do enter programs, most tend to go to agencies that have a higher proportion of female staff and that provide support services such as women's groups, legal help, educational counselling, health care, aftercare services, childcare, and programs for

children (Beckman & Kocel, 1982). However, having women together in a program is not enough. Most important is that programs and assistance be structured on feminist principles and that workers in these programs have a clear understanding of this philosophy and reflect it in their practice. If the problem is one that arises out of a context of sexism and gender inequality as argued here, then it is important first of all to have fully informed and "politically" educated women as the principal helpers in such programs. Since there continue to be greater societal disapproval and more social stigma for the addicted woman than her male counterpart, and since this stigmatization creates shame and guilt (Gomberg, 1987), women need the empathy and support of other women. Treatment cannot be successful if women are exposed to sexist practices when entering alcohol and drug programs (Babcock & Connor, 1981).

As stated earlier, most alcohol and drug programs are based on a medical model of alcoholism treatment that views dependency as a function of an individual's physical or psychological make-up. The challenge from feminists and from other alternative approaches to this disease perspective has thus far been unsuccessful in significantly influencing treatment programs. Greater flexibility in terms of treatment approach is needed, as is more attention to secondary prevention by reaching out to women who are just beginning to experience problems with their chemical use. Perhaps the most overlooked woman is the early-stage problem drinker who is not yet severely dependent. She is likely to have a short history of substance abuse, resist the disease model, and reject the need for total, lifelong abstinence. She may, however, respond to an approach that offers brief but relevant counselling with an educational component (Sanchez-Craig & Wilkinson, 1988).

We must also make a greater effort to reach out to marginalized women such as welfare, immigrant, and non-white women. This outreach work is often put aside because of the already heavy demands on women's programs and the limited resources available for additional work. Nonetheless, it is vital to these isolated and disempowered women that their alcohol and drug dependence be at least recognized. If we are to provide treatment for women who lack support, we must also be prepared to provide for their children and offer childcare and children's programs. Other services should include educational counselling, legal help, and assistance negotiating the welfare system.

It is essential that services for chemically dependent women pay

particular attention to the needs of women related to their experience with sexual and physical violence. The Women's Post Treatment Project in Winnipeg, Manitoba, a program for chemically dependent women who are also struggling with a childhood history of sexual abuse, is an innovative response to this problem. This project began when two women who worked in the addiction field recognized that many of the women they were attempting to help were victims of child sexual abuse. Programs such as this help women better understand the larger context of their dependency and thereby empower them to introduce changes in their lives beyond the cessation of drinking or drug taking.

Finally, women need to be connected to an ongoing support network. Most programs currently encourage involvement in Alcoholics Anonymous or Women for Sobriety. Despite the obvious successes of Alcoholics Anonymous, unfortunately it suffers the limitations of other male-centred programs. Women for Sobriety is still a fledgling organization. Moreover, neither of these groups engages in advocacy; nor do they connect women's drinking with societal factors. Therefore, there is an urgent need for women's self-help groups that are based on feminist principles, whether they are attached to existing women's programs or completely independent.

CONCLUSION

It is of utmost importance that counsellors in Employee Assistance Programs and other worksite wellness personnel recognize and acknowledge the social obstacles that exist for women who seek their help. Their dependency should not be viewed as only "personal" or psychological, although there is always a personal and psychological aspect to it.

There are severe problems related to alcohol and drug abuse among women in our society. Solutions are not easily found, and for sure the path to effective helping programs and prevention will require innovative and creative exploration. I believe, however, that the real challenge is to clarify what we understand the problem to be in all its dimensions. It is certainly a positive sign that there are more services that address women in particular; however, the progress of the last two decades must be built upon by continuous striving to conceptually clarify the problem and improve our practice so that women are not simply treated apart from men according to the same old tired medical model.

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TREATMENT FOR WORKING WOMEN

ENSURING EQUITABLE EAP OPPORTUNITIES FOR WOMEN

CAROL-ANN CURNOCK

Case One

Everyone in the company knew about the problems a certain secretary had. She often asked to leave early. Others could not help overhearing long telephone conversations with school principals about her son's misconduct. They knew she dreaded family birthdays, when her son would present another nicely wrapped, expensive gift, shoplifted from a major downtown store. Late reports, emotional outbursts, excuses were things her supervisor came to take for granted. He had had long talks with her and felt sorry about her situation. She was a divorced single parent. He kept giving her more time to straighten out the mess. After a string of absences, fearing dismissal, she called in to say she was not coming back.

Case Two

A middle manager with a very good position in a company was intelligent, hardworking, and capable but saw herself as fat, lazy, and a total failure. She snacked at her desk all morning; she had huge lunches with several glasses of wine and then had to make sure she threw it all up. She followed this pattern almost daily—on high-stress days, more than once. She would eat pounds of candy and then vomit, repeating the cycle over and over. Eventually she had to find another job because she knew the company was going to let her go.

The companies these women work for have some surprising things in common. They are both good organizations, household names. Each has an established Employee Assistance Program. Each trains its supervisors. Somehow, though, all the help being offered missed these women. For all the assistance they received, their companies might never have heard the term "EAP."

In order to design an EAP so that it is pertinent to today's workforce and will retain its efficacy for the future, the special concerns of women have to be taken into account. Currently women make up almost half of the labor force, as noted earlier in this book. If EAPs are going to fulfil their mandate to provide help in overcoming problems that interfere with the personal effectiveness of people on the job, then we have to make these programs not only more accessible to women but also responsive to the special needs in a working woman's life.

Despite EAPs' evolution from alcohol programs in industry in the late 1940s to broad-brush programs in the 1970s to the wellness emphasis of today, much EAP thinking has not been adaptive enough to be really beneficial to the influx of women who have entered the workforce in the past forty years. A series of articles in the *EAP Digest* in the early 1980s pointed out that women were just not using existing programs.

A number of reasons were put forward. The existing programs were not seen to be confidential enough. Women feared losing their new-found status and respect if they showed themselves to be in need of help. The old EAP models relied on constructive confrontation, which supervisors, usually male, were reluctant to use with female employees. Women, in low-status, low-paying jobs, were cheaper to replace than repair. Often programs were not well advertised and employees did not know they could go voluntarily. Even if programs were broad-brush, they were alcohol based and thus did not answer many women's needs. Counsellors were usually males who had expertise in substance abuse issues. More important, many of the issues that were important to women and did impact upon their work performance, such as daycare, eldercare, or food abuse, were not seen as EAP issues at all. Unfortunately, this set of circumstances still exists in many company programs today.

Fortunately, some companies have been able to design programs that have overcome these deficiencies and have the high usage

rates to prove it. Table 1 outlines the results of an informal 1986 survey conducted by the author of six companies. Each program had been in existence for at least one year. (Names have been withheld for confidentiality.)

TABLE 1

WOMEN'S USAGE OF EAPS

	Total no. of employees	*Total no. of women employees*	*Total no. of uses of EAP*	*EAP users as a % of all employees*	*Total no of uses of EAP by women*	*% of users who were women*	*% of uses by women for personal alcohol problems where alcoholism was the presenting problem*
Company 1	6,800	4,420	498	7.3	350	70	(3 uses) 0.8
Company 2	3,688	955	392	10.6	183	47	1.5
Company 3	4,000	1,800	190	4.7	101	53	(3 uses) 2.9
Company 4	1,700		292	17.2	127	43.5	0.7
Company 5	2,300		111	4.8	49	45	0.9
Company 6	850		187	22.0	112	60.4	0.0

PLANNING FOR SUCCESS

From these success stories a basic set of principles has emerged that can be followed by any company to ensure that the time, effort, and financial resources invested in the development of an EAP garner an effective program.

First, let us look at accessibility. Employees are only going to use an EAP if they trust it, and knowledge builds trust. For that reason women should be part of the planning and development of any program you wish them to use. Involvement includes being active members on

the EAP committee. Doing work by committee may be less efficient in the short term, but an EAP committee that fairly represents the various groups within a workplace increases confidence and, therefore, acceptance of the program.

The committee's main task is to develop a policy that outlines the roles and responsibilities of everyone involved. A policy does three very important things. One, it gives the program structure, shape, and direction. Two, it gives permission to the various parties—managers, unions, the health centre, personnel—as to how they may act in the program. Three, the process allows time for a body of knowledge to be gathered about the company's needs and about the various EAP options available. A careful matching of needs and options can lead to greater confidence in the program.

A committee that has taken the time and effort to learn about the area and to design a program becomes a phalanx of eager salespeople who have a vested interest in making the program work. Women in this role create confidence among the rest of the female workforce; they become role models for the other women in the organization.

Very often committees conduct needs surveys before they institute a program to find out what problems exist, in what magnitude, and what employees would like to see in a program. To be valid, any survey of this type should make accommodation for women to express their needs. If questions are open-ended and include topics such as daycare or eldercare or single parenting, a company will have a much better database from which to build. Too often surveys presume all employees' experiences are the same, and leave little scope for a variety of answers.

One of the tasks of many EAP committees is to hire a consultant or a consulting firm to do assessment, counselling, referral, case management, and follow-up. The development of these firms may well be the most significant factor that has enabled some organizations to increase the percentage of female employees using the program.

An off-the-premises, externally managed, professional EAP group alleviates many of the fears that might prevent employees from using programs. A program run by a group is less personality-based, and if it is external it is less susceptible to company politics. A company that has had to invest money in a program often has a greater commitment to it than to a program created by just changing a present employee's job description to include EAP. Since the outside program can

be used anonymously, women's fears of being identified are lessened. One very important factor is that a team of professionals has a much broader knowledge base, so knowledge applicable to women's needs is more likely to be within the group.

When choosing an EAP consulting firm there are many factors to consider. Certainly qualifications, location, office hours, number of counselling sessions offered, follow-up practices, track record, and cost are all important. But there are other factors as well. It is important to ask what each group knows about daycare or eldercare or victims of battering or depression. What is their attitude towards women? Do they have any women executives or owners within their own company? How many women professionals are within their associates list? We all know that less than positive attitudes of a counsellor can be very detrimental to an already troubled client.

There is a direct correlation between the way an EAP is rolled out or introduced to the workforce and the usage rate (Fabish & Cott, in preparation). The more personal and intimate the implementation, the more likely use is going to occur. Companies that are now achieving high usage rates do so because they bring employees together in small groups and explain the benefits of the program and its voluntary and confidential nature. They also introduce some of the counsellors.

Any training or information sessions should include female examples. This may seem an obvious point. However, for years EAP training sessions included such films as *We Don't Want to Lose You* and *The Dryden File*. Both films are excellent, but show only male troubled employees and male managers. The not-so-hidden message is that EAPs are for men. Posters, flyers, payroll stuffers, and the like should all include an equal share of female images.

The committee's final role is to monitor the program to make sure it is effective and that everyone is reminded of its existence. Besides a general tally of the usage rate, a record should be kept of the number of women who use the program, unless a company has so few that to keep this information would compromise confidentiality. It is vital to know if the program is of use to female employees (and if not, why not?). Otherwise, any gaps or deficiencies cannot be corrected. This information should be presented to the committee once or twice a year so that changes and improvements can be ongoing.

Program accessibility is only the first step in the solution to

providing EAP services to working women. The second issue is responsiveness to their special needs. Here we depart more radically from EAP traditions.

MEETING WOMEN'S NEEDS

Recently I gave a lecture, "Women's Issues in EAP," at a university course for EAP coordinators and counsellors. One of the men in the audience insisted that my whole topic was a non-issue. His company's EAP policy made no differentiation between male and female employees. If his company had declared them equal, I was taking a step backwards by insisting that women's needs were different.

From his point of view his arguments made sense. EAPs are not the only field that presumes that what scientific or social facts are proven true for men are also true for women. To argue for programming for women that is beyond most people's definition of broad-brush is a great leap from what many EAP practitioners see as the program's original purpose. My argument is that unless we realize that women's life experience is different from men's, EAPs will become largely irrelevant to half of the workplace in the next few years.

To illustrate the point that equality has nothing to do with being identical, I have chosen some problem areas that all EAPs should cover. One is very traditional—alcoholism. The others are very relevant to many women's lives but are not always seen as EAP issues.

Eldercare

Eldercare is an issue far more germane to women's lives than men's. In one study, 80% of those employees responsible for providing care to elderly parents were women (Winfield, 1988). Another study found: "The majority of these care givers are women, even when the person needing care is the husband's parent." The amount of time for this kind of care varies, but the average seems to be about 8.6 hours—or a full working day—weekly. If the elder shares the household, care can increase to the equivalent of a full-time job. Often, eldercare requirements hit a women when she is about 50, when childcare requirements have lessened and she is at the peak of career demands. The financial, emotional, and time commitments can contribute to stress and guilt, lessened work performance, and personal health problems. A University of Michigan School of Nursing study reported that 33% of persons caring for a relative with Alzheimer's disease used prescription drugs

for depression, tension, and sleep disorders (Winfield, 1988).

Food Abuse

More women than men become involved with food abuse disorders—obesity, anorexia, and bulimia (Orbach, 1978). There is much more pressure on women than on men to appear thin. Many women are underemployed, or are passed over for promotions, because of problems with food (Stanberg & Karee, 1986). Women who have problems with food are often adult children of alcoholics (Woititz, 1983). One-third of all food abusers also abuse other substances such as alcohol or other drugs (Perry & Burch, 1987).

Despite the profound effect food abuse can have on people's lives and therefore the workplace, it is often not seen as an EAP issue (Losee, 1988). Even if an EAP does consider eating problems, outdated knowledge and attitudes can often make things worse. We now know that the actual result of dieting is almost always weight gain, since the body's natural reaction to famine is conservation and greater efficiency (Polivy & Herman, 1984). An EAP coordinator or counsellor who thinks food abuse is not an EAP issue, or who sees it as amusing or disgusting, or who disseminates unhelpful information, is really underserving a large proportion of the workforce.

Alcoholism

As you may have noted in Table 1, even in successful EAPs the percentage of self-referrals for personal alcoholism was very low among female employees. Some of the reasons for the low rate were found in the record keeping. Only the presenting problem was noted. Many women present with other problems and then expose their alcoholism as counselling proceeds. We have a long way to go, however, before EAPs can really serve women with drinking problems.

"I didn't know she had a problem. She went to work, she looked after the kids, she kept the house. It never affected me, our relationship, our marriage." This is said by the husband of a patient being admitted for inpatient alcoholism treatment.

Alcoholism is the basic problem upon which the concept of EAP was originally founded. Unfortunately, most of the knowledge we have about it just does not apply to women. "The subjects of drinking studies—whether human beings or laboratory mice—have almost always been male" (Katz, 1981). For this reason, EAPs have largely failed the

female alcoholic. In an address to the 1988 Northeast Conference on Alcoholism and Drug Dependence, Dr. Martha Morrison stated: "There are more facilities for women in this country than there have ever been, and there is now grant money available for research on issues of treatment of women.... The problem is ... women are still not getting into treatment."

The above statement is hardly surprising. The "fallen angel" stigma that pictures heavily drinking women as shameful, as betraying their duties, as tramps (Bernardi, 1982) is still a powerful disincentive, ensuring that women keep their secrets to themselves.

For this very reason, the premise upon which EAPs have been based—that is, that addiction problems will manifest themselves in poor job performance—often does not apply to women alcoholics. They work much harder to hide their problem, knowing they will be much more severely judged. Also, women are often underemployed, so they can cover up performance deficiencies more easily. They are also more likely to substitute tranquillizers or sedatives for alcohol during working hours, so that they are less likely to be observed drinking.

Constructive confrontation is not nearly as effective with someone in an underpaid, negative job situation. Also, attitudes are difficult to change. Articles suggesting that supervisors are unwilling to confront women or are more likely to attribute difficulties to "women's problems" or "emotional problems" are just as prevalent now as in the early 1980s.

All of this really leads to the conclusion that EAPs will have to change if they are going to include women alcoholics. Making EAP use possible on an anonymous basis can eliminate many of a woman's fears about losing respect because she has a problem.

What about the woman who needs some encouragement to seek help? There is much evidence to suggest that girls' and women's moral development is based on sustaining relationships and caring for others, as opposed to male morality, which is based on resolving conflict through rules (Gilligan, 1982). To build on what is already there, fellow female employees can be given permission, through training, to act upon their natural impulses and suggest to a fellow employee that she go for help. This is a little different from the peer-referral model, which has proven problematic in some settings because of confidentiality and skill issues.

The Association of Flight Attendants in the United States trained volunteers to be "change agents" acting as motivators to get co-workers to use the EAP. The idea was based on the concept that "For women, social behaviour rather than job performance is often indicative of a problem" (Pape & Rivard, 1988).

Another way this knowledge can be put into action is to set up self-help groups for women only. Dr. Colleen Lundy, School of Social Work, Carleton University, strongly suggests that self-help groups are supportive systems that women need in order to overcome dependent behavior because they seldom have partners to help them through recovery, and because they are so often the victims of violence, almost always at the hands of men (Lundy, 1987). Of the addicted women she studied, 64% were physically and verbally abused by their partners; 36% were victims of incest. Alcohol was used to escape alienation, loneliness, and physical and emotional pain. Self-help groups would be vital to attaining—and maintaining—recovery. One of the most often repeated themes about dependent persons is that they lack self-esteem. The difference is that while dependent men have low self-esteem, dependent women have no self-esteem (Smith, 1988). Therefore, one of the most important features to be uppermost in the planning of any EAP is to be supportive of feelings of self-worth for women. Any feature—whether policy, training, advertising, assessment, counselling, or wellness information—that is undermining or blaming, critical, or adding a further burden of guilt, has no place in a program designed to be helpful to the workplace.

FINAL COMMENT

Obviously, these are just a few of the issues with which working women have to contend. Drug abuse (including the increasing attraction of cocaine), sexual abuse, and childcare needs rate high among the problem areas not covered here and inevitably affect their working lives. The bottom line is that outmoded patterns, limited programs, and old definitions are not only unhelpful but costly and wasteful of a significant proportion of our society's working potential. Can our workplaces really afford inappropriate EAPs?

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FEMINIST COUNSELLING: A Woman-Centred Approach

HELEN LEVINE

I want to comment briefly on how I became a feminist counsellor and how feminists view the commonality of girls' and women's lives. I came to this approach by way of trying to combine my experience and skills as a social worker with my awareness and experience as a woman. It began as an attempt to translate into practice changing perceptions of myself and other women in this society. As with most of us, this development did not arise apart from changes and crises in my own life (Levine, 1982).

It is important for me to state that I have been on both sides of the institution and the desk, as provider and consumer of service.

As psychiatric consumer, in and out of hospital, I was "helped," as were others, to see my problems as individual, pathological, personal, and blameworthy. I was not helped—except by other patients, some friends, and the women's movement—to see myself as only one of countless numbers of women with similar life stresses and strains that cry out for political as well as personal solutions.

My experiences, particularly in hospital, taught me to distrust contemporary professionalism and institutions. Sometimes the most humane and thus most effective staff were non-professional, everyday people such as nurses' aides and cleaning staff. Their humanity and

simplicity seemed to have been better preserved than that of many professionals whose lives were primarily invested in careers, status, and image.

Beginning with my own experience, connecting my struggles with those of other women, is central to being a feminist and to feminist counselling. Though questions of race, class, age, and life experiences impact very seriously and differentially upon many women, the broad outlines of most women's lives are at the same time strikingly similar.

We have been required, for example, to view happiness and contentment within restrictive and limiting contexts. Often, the absence of severe problems with a mate, rather than the presence of a rich and challenging life, is seen as the good life for women. Men become partners, fathers, and workers. Women are not supposed to aspire to such an integration of life if it is in any way significantly disruptive to others, if in any way it impinges significantly on men's needs and aspirations or on the lives of children. This is partly what patriarchy is all about. Women have been directed to be loyal, first and foremost, to individual men in their lives, and to blame themselves or other women when trouble emerges. Under such conditions, solidarity among women in pursuit of change is and has been profoundly undermined.

Contemporary feminist thought, building on feminist movements of the past, describes the world as having been historically defined by men and for men, with women seen as subordinates within and outside the home and as marginal to fundamental questions of power decision-making and leadership in both personal and public spheres.

The nuclear family—that is, one woman and one man in a heterosexual relationship with 2.5 children—constitutes a relatively small percentage of family composition in North America (Eichler, 1983). Yet the myth of the nuclear family as the norm, the way "healthy," "normal" women live, remains deeply entrenched as a central life prescription for women.

In reality, many ways of living and loving and sharing exist now, and some have existed throughout history. They include lesbian couples; celibate women; single mothers; separated and divorced women with or without children; lesbian mothers; never marrieds; and couples who choose not to have children. The trouble is that patriarchal institutions (such as organized religion, the traditional family) have vigorously

promoted the nuclear unit as the only normal and acceptable family form. All other alternatives, especially for women, have been labelled deviant, sick, or "a social problem." It has taken the contemporary women's movement to reject theories of normalcy that require women to live as dependants and adjuncts of men, and to expand notions of family to include the many different ways in which human beings live together.

"Sex-Role Stereotypes and Clinical Judgments of Mental Health" is a classic study that exposed the double standard of mental health for women and men (Broverman et al., 1970). It investigated the responses of both female and male clinicians regarding characteristics said to be found in a healthy woman, a healthy man, and a healthy adult. Results indicated that clinicians' definitions of a healthy man were equated with those of a healthy adult. Their definitions of a healthy woman were not. The implications of this study for women who seek treatment are profound, given the common clinical assumption that the normal behavior of women and that of adults do not coincide.

Men's stress and distress are generally linked with occupational hazards—too much pressure or responsibility on the job, or unemployment, or absence of adequate nurturance and support at home. For women, stress and distress are typically defined as mental health problems. Our turmoil is not linked to the occupational hazards of childcare and domestic labor, to poverty, unemployment, or the double workload, to the misogyny that assaults us at multiple levels. We are not expected to even claim a support system at home—we are supposed to provide it. Women's distress is said to be primarily "in the head" (Levine, 1983). Women, on the one hand, aspire to becoming full and significant human beings in the world at large and, on the other, learn to be female. The latter demands that we give up the self, yield our own individual potential in the name of love, reason, or normalcy. The main thrust of our lives, we are told, is to care for and about others.

The inevitable conflicts created by such a prescription for women results in severe personal difficulties at one point or another in our lives. It is then that we are frequently perceived by the traditional helping professions as inadequate, abnormal, or sick individuals who need to be assessed, diagnosed, treated—in fact, controlled. We are not and have not been seen by these same professions as a major oppressed group that struggles daily with the poverty, subservience, and/or violence built into the very structure of our lives.

Feminists hold the traditional helping professions responsible for negatively defining, categorizing, and labelling women's struggles and behavior out of political context, while frequently finding "good" reasons—legitimate causes—for men's and children's difficulties. Even regarding male violence against women such as wife battering, rape, incest, and sexual assault, the question is most often put in terms of what women do or do not provoke, what women should or should not have done.

Before the contemporary women's movement emerged in the 1960s, professionals did not consider these questions worthy of attention, in theory or in practice, other than from a highly individualized and pathological perspective. It was feminists who first exposed issues of rape and wife battering; who connected and made visible the personal and political implications of men's violence against women in and beyond families; who demanded and frequently set up crisis centres, transition houses for battered women and children, support systems of various kinds, often without money, buildings, staff, or status. The women's movement has demonstrated that, in dealing with such issues as motherhood, heterosexuality and homosexuality, families, paid and unpaid work, and violence against women, a clear and active feminist framework is essential.

This is the feminist framework within which I want to explore the possibilities and limitations of Employee Assistance Programs (EAPs), and the implications for women who may or do use these services.

WHAT IS FEMINIST COUNSELLING?

> Women do two-thirds of the world's work...yet they earn only one-tenth of the world's income and own less than one percent of the world's property. They are among the poorest of the world's poor. (Conable, 1986)

Amidst the rebirth of modern feminist thought and a central emphasis on consciousness raising, women shared a great deal of personal information and personal pain with one another. Much of the sharing had to do with "the problem that has no name" (Friedan, 1963). It highlighted the negative experiences women had and were having at the hands of psychiatry in particular, but also with the helping professions in general. It revealed how women's daily struggles to survive had led them to seek help from the very sources that were defining their struggles as sickness and pathology. Feminist literature—fiction and

non-fiction—was rapidly documenting the sexual politics of modern health care.

There is a large and growing literature on feminism, gender, counselling, and therapy (see References). But for the purposes of this chapter, I want to set out some of the basics of both receiving and providing help from a feminist counselling perspective.

First and foremost, I wish to say that for me feminist counselling is not a technique or series of techniques. Rather it is an approach that rests within an explicit feminist framework as part and parcel of the counsellor's ways of seeing and dealing with her own and other women's lives. Feminism fundamentally informs these ways of seeing and defining human behaviors, internally and externally.

Feminist counselling is a helping process that has to do with working with women, individually or in groups, around their life circumstances in relation to the society that has shaped them. It has to do with facilitating change with a focus on women helping women in a non-hierarchical, reciprocal, and supportive way.

Personal stress and distress are seen as a barometer, a kind of "fever rating" connected to the unequal and unhealthy structures, prescriptions, and power relationships in women's lives. There is a rejection of the artificial split between internal feelings and external conditions of living and working, between human behavior and structural context. A feminist approach to working with women involves weaving together personal and political issues as causes of, and potential solutions to, women's struggles.

By defining personal problems from a political perspective, feminist counsellors are able to move in new directions in helping. For example, when women are immobilized with depression, they may well be on strike against killing roles and expectations. When women end up in psychiatrists' offices or dependent on drugs, it may be that they are political refugees from narrow and suffocating lives. When women on public assistance are listlessly apathetic or exploding with anger, their responses are most likely rooted in their powerlessness and poverty and the daily control of their lives by the state. This approach reflects the linking of the personal and the political in the feminist counselling process.

Feminist counselling, then, looks at the political implications of women's struggles and behavior, at the personal consequences of

women's limited control over their own space and lives in families, paid workplaces, and public places.

The traditional family is seen as an institution that has been a particularly effective vehicle in the oppression and containment of women. It is also an institution that the helping professions frequently strive to uphold, no matter what the cost to women in the process. Yet studies on depression among women suggest that an intensive commitment to marriage and motherhood as primary tasks in contemporary life is potentially "crazy-making" (Bart, 1971). Given the double standard of sexuality and aging, this is work offering little job security.

Feminist counselling recognizes women's entitlement to full adult involvement in the world. Thus there is recognition of the importance of significantly increased public participation and leadership for women, and significantly decreased domestic and childcare responsibilities. Though men verbally glorify women's roles in the home, they seldom wish to exchange.

There is a central assumption in feminist counselling that "women's work" and "women's place" in society are key factors in producing much distress among us. Thus the sexual division of paid and unpaid labor in and beyond the home, its impact upon self-esteem and interpersonal relationships, is a key connection to be made. It is also understood that chronic responses of guilt, self-blame, and depression in women have more to do with the general subordination of women than with childhood, personality development, or patterns of communication.

Feminist counsellors are concerned with the unequal power relations between the sexes as the source of much unhappiness among women. This inequality plays out in the paid workplace as well as in the domestic sphere. Thus such issues as earning power and money, decision-making, sexual relations, primary or exclusive responsibility for domestic labor and childcare, and job ghettos form part of the framework within which personal problems are explored.

This approach refuses to blame the victim or to define women's personal struggles as individual pathology, via the medical model. As feminists, we personally have been helped by the women's movement to consciously address these issues in our own lives. As providers of service we use the commonalities between us as a way of understanding, sharing, and helping.

The answers to women's struggles do not lie in therapeutic blueprints. They most often lie in a redefinition of the problem itself (Levine, 1982).

WOMEN, ANGER, AND COUNSELLING

Women's anger is of crucial interest to feminist counsellors. "First and most important, it exists and it is huge" (Mueller & Leidig, 1976). Women have a great deal to be angry about in a sexist society.

Yet all mainstream definitions of "femininity" have perpetuated the myth that truly feminine women are generally devoid of serious anger and aggressiveness, especially towards men and children. We have been allowed the expression of rage only in defence of others or in relation to other women. To express anger on our own behalf—especially towards men, and especially if done effectively, directly, and powerfully—is labelled unfeminine, inappropriate, sexually unattractive, and, if carried "too far," hysterical or abnormal.

The taboos against women feeling and expressing anger are so powerful that even *knowing* when we are angry is not simple. Given such strong prohibitions, we frequently seethe internally and then turn our anger upon ourselves. It is a formula for self-destruction that has resulted in a contemporary epidemic of depression among women.

The strength of this taboo means that there is a problem in even speaking about women and anger.

> One topic most people really don't want to hear about is women's anger. Our culture [and others] has a long history of surrounding this topic with dread and denial.... It is virtually always [seen as] pathological. (Miller, 1983)

Women's anger and our ongoing attempts to hide it, even from ourselves, is responsible for much unhappiness. We need our anger as much as we need any other emotion. It bears within it strength, energy, drive, clarity, and determination. These resources are crucial in terms of acting upon and taking control of our lives.

> The fundamental lesson to be learned from female depression is that in anger there is power.... [For] there is no way to regain your sense of power without engaging in [this] process of allowing your anger. (Greenspan, 1983, p.304)

In terms of feminist counselling, it is critical to tap women's anger, to validate it, to make plenty of room for it, and to redefine its

causes. There is empowerment to be discovered in this emotion, including self-esteem and the right to one's own adult responses. There are reasons why women's anger is so threatening to men in particular. If we remain guilty, self-doubting, and depressed, we tend to stay passively "in our place." If we begin to lay claim to our anger, we are no longer so docile and may well be on our way to new ideas and actions that have to do with empowerment and becoming subjects in our own lives.

> I do not see letting go of anger as a matter of getting it out so that we can forget it. It is a matter of unleashing it from the repressed, indirect and self-destructive forms that strangle us so we can use it in more conscious, active and collective ways.... So that we can use it on our own behalf. (Greenspan, 1983, p.305)

Assertiveness training for women can be valuable. However, there is the danger with this approach that women will continue to worry about doing things "properly"—no aggression, only assertion—and thus be prevented from experimenting freely and finding our own best ways of locating and using our anger.

I want to share two opposing ways of working with and defining women's anger.

I. The following is an example of the danger lurking from within psychiatry in relation to negatively diagnosing and labelling women's anger. First, of course, the anger is converted into a "syndrome," a pathology.

> Specific common denominators in the angry woman syndrome set it apart from any established present-day classification. These symptoms are periodic outbursts of unprovoked anger, marital maladjustment, serious suicide attempts, proneness to abuse of alcohol and drugs, a morbidly oriented critical attitude to people and a contrary obsessive need to excel in all endeavors, with an intense need for neatness and punctuality. This constant striving for perfection is their undoing.... They resent treatment and blame their husbands for the problems that are presented. (Rickles, 1971, p. 91)

This assault on women, in the name of professional theory and practice, is a chilling example of how women are "clinically" blamed for their anger, marital conflict, and ambition, among other things, unrelated to the reality of their daily existence. Were Rickles and his ilk to be slotted into female roles of service and subservience, would their anger constitute a "syndrome," or courage and strength? Or is the classification to be reserved for one sex?

II. The following is an example of a feminist counselling approach to women and anger.

> Lynn (not her real name) said she had not realized her anger was an ongoing issue while she was drinking, she hadn't made connections between drinking, anger and being female. Yet not being able to express anger was painful. She had learned to direct her rage against herself, to blame herself, and she had shared this with no one. Her life story was very complicated, and as she put it, "You can take for granted, with women and addictions, that the past is filled with horrors."
>
> She stopped drinking and went for help to a feminist counsellor, in order to deal with the issues that had driven her to this addiction.
>
> At the very outset, the counsellor dealt with anger and its anticipated expression by reassuring Lynn that she both expected and could deal with her anger. She would be by her side, no matter how angry Lynn might become. The counsellor simply saw anger as a given theme in women's lives, shared her own personal need and capacity for its expression and use, and repeatedly made this theme clear throughout their work together.
>
> Lynn later told me that it was feminism and the women's movement that gave her permission to be angry in the first place. But it was the feminist counsellor who personally "validated my anger, my whole life." Her anger emerged mainly in tears, in "saying the unsayable." She had always assumed she had no right to be angry. Claiming this emotion was a liberating experience with many unexpected and positive consequences. She realized that if she had the right to be angry, she also had the right to nurture herself, to stand tall as an individual. Claiming anger was an "open sesame" to begin to claim other entitlements as a woman.
>
> For Lynn, the clear and repeated legitimation of women's anger "gave me a lifeline and was the basic missing piece" in taking hold of her enormous strength and potential.

Women often attempt to contain, to deny, to put a lid on their anger out of a profound and realistic fear of violence, poverty, abandonment, or being driven "crazy." Men's punitive responses to women who do claim their anger can be deadly and/or crazy-making. The subtitle to *Women Look at Psychiatry* (Smith & David, 1975)—"I'm Not Mad, I'm Angry"—speaks volumes to many women. Our internal fears and anxieties revolve around the realization that if we really let go, the consequences could be dangerous and/or life threatening. Better to

keep the peace, whatever the cost to our own dignity and self-respect.

Literature on battered women attests to the endless attempts by women, young and old, not to provoke their mates or their dates. The emphasis is on anticipating men's needs and wishes and moods, on avoiding comments or actions that may become the excuse for violence. The emphasis is on survival, physically, emotionally, and economically.

Serious economic issues for women often determine whether or not we express or act upon our anger.

Many women, of varying ages, are economically dependent upon men. In intact families, money is a powerful tool to induce female conformity and is frequently used by men as threat, bribe, or reprisal. Frequently women's part-time earnings go into a common pot controlled by men who act as "management." For women, incomes take a sharp downward plunge following separation and divorce, while men's incomes rise in similar circumstances. Support payments for children to mothers by fathers have historically been partial, unpredictable, or nonexistent.

The point I wish to make is that women at one and the same time have a great deal to be angry about and yet dare not, in many instances, express or act upon their anger. As Miller puts it,

> There is great risk in disturbing the relationships which provide one's economic substance and one's whole psychological place in the world. Simultaneously, living in this kind of dependency continually generates anger. (Miller, 1983)

One of the reasons why many women remain within unhappy or violent situations with men is the dreaded prospect of poverty and perhaps welfare, for themselves and for their children. There is enormous guilt at the thought of children being "unnecessarily" deprived, materially, by virtue of a mother's refusal to accept further abuse. There is also major concern around depriving children of a "normal" family unit: that is, mother, father, and children. The question, of course, is what is normal? Here the whole issue of redefining family, normalcy, and other patriarchal ideas from a feminist perspective becomes crucial.

Is it normal for women to be dominated, controlled, or abused by men? Is it normal for women to be adjuncts and subordinates in families? Is the intact family necessarily normal? Are families composed of mothers and children abnormal? Why? What about the large number of women who carry virtually all parenting responsibility in two-parent

families? And what does all this have to do with women and anger?

Where there is inequality, there is conflict. And where there is conflict, there is inevitably anger (Miller, 1976). Certainly all signs point to the inevitable presence of this emotion in women's lives, whether acknowledged or not.

There is a tendency to see anger as an all-embracing, central characteristic in those women who openly claim it. Such judgments, spoken or unspoken, as "There goes one angry bitch," or "My God, she's strident and hostile," or "What a raving madwoman!" are common ones reserved for women. The tone of voice that speaks such judgments is usually filled with contempt or hatred. I want to make the point here that women, much more than men, are capable of very loving, tender, and caring emotions. Anger does not exclude loving, and loving does not exclude anger. In fact, getting at our anger as women is an important route to freeing up very positive feelings about ourselves and others.

There are no standard ways for women to express anger. Different women take different directions at different times. Sometimes our rage gives us a growing sense of clarity, strength, and determination. Other times we experience helpless rage. It is hard, sometimes, to distinguish one form of anger from another or to comprehend the mix of strength and impotence that may be embedded therein. For counsellors, it is very important to recognize that anger, however loud or soft, can be both a cry of desperation and an expression of strength and determination.

A common complaint about women's groups is that they make women angry. From a feminist counselling perspective, such groups don't make women angry; rather they help women to recognize that they, and women generally, are and have been angry for a long time, for very good reasons. Women's anger may be one of the reasons why many clinics, social agencies, and hospitals are reluctant to establish women-only groups or services. Women tend to remain more docile in mixed groups, to defer to men, and to avoid their own loaded topics (i.e., battering, incest, rape). Conventional practitioners often see this as appropriate, normal behavior for women. Their emphasis is on "normalizing" experiences, which are assumed to be women and men together in a heterosexual context. A reflection of how gender-blind many helping professionals and their services remain lies in their lack of interest in organizing the small women-only groups that have histori-

cally helped women reclaim their strengths, their dignity, and their self-esteem.

MOTHERHOOD

I want to briefly touch on motherhood as an experience in which women's anger can be both complex and intense, and which can particularly benefit from a feminist counselling approach.

There is a powerful taboo against the expression of anger for mothers in particular. Mother love is considered natural and instinctive, and the patriarchal prescription for motherhood promotes love, tenderness, patience, and self-sacrifice. It does not sanction feelings of anger, rage, or resentment.

> As women, we are given an awesome task by our culture: to be fully aware of our "positive" emotions and develop our capacity for love and nurturing, while at the same time dismissing our "negative" feelings such as anger and sadness. This is an intolerable double bind. (Wyckoff, 1977)

The control of anger creates guilt and self-blame. Painful emotions, allowed no legitimate validation, become focused on mothers themselves, turned inward rather than outward. We start to believe that "There must be something wrong with me. If I were a better, more worthy wife and mother, all would be well. I must be the problem" (Levine & Estable, 1981).

Motherhood is an area in counselling, as in life, where women are in particular danger of being scapegoated, blamed, and silenced (Caplan & Hall-McCorquodale, 1985). Conventional psychiatrists and therapists almost routinely become preoccupied with what mothers have or have not done, past and present.

Given that the majority of practitioners and authors in the areas of childhood and the family are male—from pediatricians and obstetricians to psychologists and psychiatrists—the "shoulds" for the tasks of motherhood have been defined by those with the least direct experience and responsibility for childcare and families. The very real expertise of women in this area has been devalued and largely ignored.

It is here where the lived experience of women becomes invaluable as knowledge for counsellors. Women breaking the silence around motherhood and its implications for women give the lie to much of what

is written and practised by men on the subject. The following illustrations provide a glimpse of the reality.

> My children cause me the most exquisite suffering of which I have any experience. It is the suffering of ambivalence: the murderous alternation between bitter resentment and raw-edged nerves, and blissful gratification and tenderness. Sometimes I seem to myself, in my feeling towards these tiny guiltless beings, a monster of selfishness and intolerance. Their voices wear away at my nerves, their constant needs, above all their need for simplicity and patience, fill me with despair at my own failures.... And I am weak sometimes from held-in rage. (Rich, 1977)

> One of my most liberating and yet frightening experiences as mother of an adolescent occurred during a trip with my husband. Triggered by an angry episode with my daughter, I screamed and cried my accumulated rage for hours within the protective walls of a moving car. Why was this experience at one and the same time both liberating and frightening? The fear had to do with seriously breaking the taboo of motherlove; the liberation came from claiming my fury and from validating my own emotional way of being me. (Levine & Estable, 1981)

A full and ongoing grasp of the inequalities, overwork, and unjust pressures for mothers, in comparison with fathers, is fundamental to any useful work with women, men, and children. Without a feminist consciousness and a readiness to listen to and respect women's real experience, past and present, not much will be accomplished. Not much will change.

Space does not permit an exploration of how women are also required to do the "mothering" of people in general and men in particular (i.e., bosses). The profound exploration embedded in this double standard of work for women and men must be confronted if women are to receive any significant assistance from a counsellor.

Inviting women to connect with their anger does not necessarily bring quick or easy acceptance. It is crucially important that EAP counsellors grasp how and why women work so hard at containing or diverting the anger around us and within us, as a means of survival. But anger can be claimed, and it often surfaces as a woman begins to get a sense of her own strength, her own potential, her own claim to be a full and separate adult in her own right. There is a powerful connection between validating one's anger and taking back the self, the sturdy central core of which girls and women have been robbed in a sexist society. The

critical question is whether this aspect of women's lives is respectfully and seriously addressed in a counselling relationship.

DOES FEMINIST COUNSELLING IMPOSE AN IDEOLOGY ON OTHERS?

Does feminist counselling mean imposing an ideology on others? This is a very important question. My response is that if there is not a clear and fundamental working respect for consumers, for their particular pace, preferences, and priorities, then the approach is not working. All providers of service have a bias, implicitly or explicitly. The feminist counsellor has a responsibility to make her own bias explicit, to share her view of women's place in the world when it seems relevant, as it pertains to the consumer's life struggles or to aspects of her own that may be helpful regarding the issues at hand. Consumers of feminist counselling may or may not move into or out of paid or unpaid work, into or out of the women's movement, into or out of relationships. These are decisions to be made with full knowledge of possible costs and benefits and with the advantage in feminist counselling of not having oppressive societal norms reinforced about what women should or should not be. Women, all of us, take distinctive and sometimes unusual paths towards change.

FOR WHOM IS FEMINIST COUNSELLING APPROPRIATE?

Most women. Though more and more women are seeking out female doctors, female counsellors, female healers of varying kinds, it is also true that some women are fearful of the word "feminist." Patriarchal ideology and patriarchal culture permeate women's thinking and action in subtle and not so subtle ways. Women too have been taught misogyny—that is, contempt/hatred for women—so that sometimes consumers think they will be safer with a man in charge, that a male expert is, ipso facto, superior to any woman. Obviously, this myth needs to be explored with women looking for help. In the final analysis, however, a woman must remain in charge of her own decision-making, her own choice, her own readiness.

The ways in which counselling options are dealt with is very important. Feminist counselling can be discussed by EAP staff with either a negative or a positive message. A thoughtful and positive approach will mean owning and expressing the conviction that feminist practitioners have knowledge and experience that is exceedingly valuable and underrated; that women open up and share much more easily in a

women-only context; that there are issues shared by every woman in a sexist society; that feminists have developed rich, alternative ways of working and healing. Given this kind of approach, some non-feminist women will try the unknown or relatively unknown rather than the traditional route.

Personally, I use the term *feminist* counsellor because I work on my own and because the term unequivocally describes who I am and wish to be and how I work. I take pride in being a feminist; it is a central and public theme in my life. However, there are feminists who work in settings where feminism is deemed a liability rather than an asset, and who cannot afford to be so specific—their jobs are on the line. There are counsellors who do not wish to attach a label to their work, or who think mainly in terms of being particularly concerned with and sensitive to the plight of women. In other words, there are differences. As far as I am concerned, these differences are welcome and offer a range of possibilities for different kinds of women as consumers.

The issue is, as always, the strengths and weaknesses of counsellors in terms of ways of thinking about and working with women. Personally, I refer only to known women, and I therefore need to be connected with a feminist network. If I am stuck, I consult with feminists I know well and together we can usually figure out positive possibilities. When I refer to an agency, clinic, or service, I refer to individual women whose work I know and trust.

Many women are determined to avoid the psychiatric route, the chemical traps, the endless pathologizing and intellectualizing via various forms of psychiatric "treatment." For these women, feminist counselling offers a safer, much more positive approach that highlights an emphasis on strengths, resources, empowerment, and action.

Often women who seek out a feminist approach have had profoundly destructive experiences with mainstream psychiatry and male therapists. I think it is positively dangerous for women to enter into marriage counselling, for example, with anyone who is lacking a feminist perspective. So too for lesbian women, or those for whom issues revolve around male violence, money, or motherhood. The bias in favor of men and fathers, the proneness of both male and female mainstream clinicians to unjustly blame and pathologize women's behavior, is simply too pervasive to ignore. It constitutes a very serious health hazard for women.

Suicidal thoughts are common among women during periods of stress. Such reactions would not be seen by most feminist counsellors as reason for a psychiatric referral. I think it is often fear of responsibility that drives conventional counsellors to refer such women to psychiatry. A vote of confidence in the person's capacity to take hold can be far more effective than any psychiatric referral. I have seen it happen repeatedly. Personally, given the psychiatric practices still currently in vogue (ECT, male dominance, chemotherapy, incarceration), I feel women are much better off completely avoiding such "treatment," compared to the risks of getting involved in the psychiatric industry (Burstow & Weitz, 1988).

In the end, I see a feminist counselling approach as central and essential to any good counselling. I also see as central what any particular woman decides she is ready for or would like. If that sets up a contradiction, so be it.

IS FEMINIST COUNSELLING DIFFERENT FROM "GOOD COUNSELLING"?

First, why bother with feminist counselling if it is simply good counselling? The question tends to either trivialize or invalidate a radically different way of thinking about and working with women by implying that there are really no fundamental differences in approach at all. No problem! Good counselling, from a conventional perspective, is seen to involve working with human beings (not gender specific) and with social issues or concerns such as poverty, sexuality, addictions, "family" violence, aging, marital conflict, and parenting (also not gender specific).

What has happened with this approach is the omission of the *particular* situation of half the population. It is way of rendering invisible the lived experience of women as unequal and subservient adults. It is simply assumed that females and males, despite the personal, economic, and social injustices visited upon women alone, struggle with the same human dilemmas in much the same way. Feminism squarely confronts this lie.

Bernard coined the concept His Marriage & Her Marriage (Bernard, 1982) to highlight the particularity of women's lives. His Old Age & Her Old Age are clearly two distinct experiences in vital ways. Elderly women are the poorest people in Canada (Cohen, 1984) and most often remain key caretakers of men and needy others until close to infirmity or death. The feminization of poverty is yet another example.

In counselling, as in life, it is impossible to address any personal or social concern without taking fundamental inequalities into central account. Such inequalities produce, promote, and maintain dominants (men) and subordinates (women), and permeate every aspect of life (Miller, 1976). There are other critical variables such as class, race, sexual preference, and age that shape women's behavior and experience and require respectful attention and comprehension in any good counselling.

Feminist counselling has created new directions for women based on rethinking the personal and political context of women's lives. Feminists no longer trust knowledge or theory that lacks a clear connection with the daily reality of women's multi-level struggles to survive in, let alone change, a male-defined society.

So is feminist counselling different from good counselling? My answer is, absolutely. And I would suggest that there can be no good counselling without a central feminist component, when working with women, men, or children.

MEN WORKING WITH WOMEN?

It must be abundantly clear that I view the best possible way to offer assistance to women is through women helping women from a feminist perspective. For myself as consumer, I would consider no other approach. This is not necessarily the view of all feminists, though the emphasis would lie heavily in the same direction.

One question that emerges is whether some men can be feminists or feminist counsellors in the first place. My answer is no. Feminism arises out of the oppression of women, out of the inequalities between women and men that result in fundamentally different experiences and issues in our lives.

Feminist counsellors recognize that a form of biculturalism and bilingualism—two solitudes, two languages—exists between women and men. For women, the daily process of editing one's thought, censoring one's statements, remaining silent in the face of controls or insults, withholding ideas and anger, is common everyday experience in relation to men. It shows up glaringly in public forums and conferences, where men quickly take over the available space and time and talk and where most women tend to be silent or subdued, often fearful of looking or sounding foolish.

In general, women have been taught dependence and passivity and deference in relation to men. So to replicate this common situation with a male counsellor means running the risk of making women more vulnerable at the very point where they need to develop strength and purpose and determination.

However, the question remains regarding EAPs, which have many male counsellors and male employees on staff. Can they be helpful?

First and foremost, EAP counsellors need information and training by feminists about key issues in women's lives and effective ways of working with women. They need to muster the humility to do a lot of listening to and learning both from women who are feminist counsellors and from female users of service. This is not simple for males who are accustomed to taking charge and assuming dominance. It means yielding privilege and power and airtime—a painful prospect and process for many men.

One of the best and most essential training grounds for male counsellors is within their own daily living and working arrangements with female partners, sisters, mothers, daughters, female colleagues, and female employees. Are they learning, are they changing, are they struggling towards new and respectful ways of connecting with women? Are they listening? Do they challenge male friends about sexist behavior? Do they challenge their own sexist behavior? Do they raise feminist issues publicly with other men—rape, incest, poverty, job ghettos, sexual harassment?

As a woman and a feminist, I am respectful of those men who are actively and continually "struggling towards" gender equality, in a profoundly serious personal and political sense. I am not at all impressed with men taking "correct" political positions on feminism while their personal behaviors towards women at home and beyond reflect contempt, superiority, or an unwillingness to acknowledge their privileged position. As Landsberg has written, men have had an affirmative action program in place for centuries (Landsberg, 1983). Do they know that they have usually been hired and promoted and invested with authority primarily on the basis of gender rather than competence?

Training men regarding feminist perspectives is a contentious issue. Why should women or feminists spend time and energy on such projects when it is the women who most desperately need and value our

services? There are unfortunately many parallels in the paid workplace where experienced and competent women—bank tellers, for example—train men who then move on to be promoted into well-paid careers and in turn supervise these same women.

The first and essential point is to hire numerous feminist women for EAP programs in the first place. And to promote such women into decision-making positions, in decisive numbers, in order to make a difference. This is the fundamental test of integrity regarding services for women.

I want to comment on a local program, run mainly by men, that seems to be moving in responsible and alternative ways regarding the oppression of women. The men are working with men who batter, in groups. Male staff members are themselves involved in the study of feminism and how it continually challenges them in their own personal and political lives. They consult on a regular basis, formally and informally, with advocates for battered women in the community, to help maintain their anti-sexist ways of working and to remain accountable to the battered women's movement. They sponsor women's groups for the partners of men in the program. These groups are facilitated by active feminists. There is no question here of female and male users of service meeting together. There is recognition that women-only groups are essential for women.

A concrete aspect of this project highlights the choice between traditional professional practice and a feminist approach. The safety of the women partners of men in the program is the prime objective of the work, on both an individual and program basis. For example, the men are explicitly told from the outset that counsellors intend to break confidentiality if there seems to be danger of violence to their partners, and that the needs and rights of the women will be kept front and centre in the men's sessions. This is an absolute priority defined by battered women's advocates and adopted by male staff. In other words, counselling objectives with the men, though obviously important, are not primary (Player, 1989).

I mention this program not to laud men for taking small steps in the face of huge atrocities consistently visited upon women. Nor do I wish to minimize the ever-present danger of such programs diverting the focus of concern and funding sources away from female victims of violence to the criminal offenders. My attempt here is to illustrate that

change is possible if personal/political issues are seriously addressed, and if men begin to face their own individual and collective responsibility for women's oppression.

Male counsellors need to confront their own limitations in working with women and to share these limitations openly with female users of service. They need to learn from women in an ongoing way what it is like to be the second sex. And they need to see this learning as a central challenge to their competence as good counsellors.

Some of my comments about male counsellors unfortunately apply to some female practitioners as well. Female helping professionals are sometimes male-identified and anti-feminist. They are sometimes concerned with developing competence, expertise, and status within male-defined hierarchies, and thus conforming to conventional theory and practice. It is in such instances that the absence of a feminist perspective can be harmful and discouraging for female consumers. Seeing a woman counsellor in no way guarantees respectful or effective help. I do not at all mean to imply that many more women are not needed in the helping professions. They are. I wish simply to state clearly how critical a feminist perspective is to the work of both women and men.

Referrals are a large part of the work of EAP counsellors. So how do male counsellors begin to know the resources—individual and community services—that are likely to be of benefit to women?

Again, they will have to do a great deal of learning, exploring, and consulting if they are to discover and help develop these resources. It is much easier and faster to refer women to traditional services, to clinics and agencies, or to well-known mainstream practitioners and consider the job done. A feminist counselling approach demands very cautious and differential referrals, taking gender into central account. They would be made to particular feminist services (e.g., Interval House, Women's Career Counselling, Pink Triangle Services, Sexual Assault Support Centre) or to particular counsellors who have intimate knowledge of what women's internal and external struggles are all about. Feminists work within voluntary agencies and clinics, but they need to be known in order for the EAP counsellor to make specific referrals. It takes much more time and effort to ferret out these resources. They are not numerous, easily available, or visible. EAP counsellors need to develop and update lists of feminist services and counsellors, read extensively the wide range of current literature on new approaches

to women, counselling, and therapy, and critically examine their own ways of working and their own program in order to make them more relevant to women.

Ideally, they would recognize the enormous gaps in their own knowledge about women and concentrate on working with men around gender issues. They need to set up regular paid consultation and training sessions with feminists from inside EAP programs and with grassroots feminists from various women's services in the community.

KEY CONSIDERATIONS IN FEMINIST COUNSELLING

- An underlying assumption of feminist counselling is that women have the potential strength to forge changes in their lives, especially together with other women. There is a rich appreciation of the joy, the sense of purpose, the self-esteem, and the confidence that comes of tackling keenly felt issues with others who share similar experiences.
- One key strategy is helping women to reassess the value of relationships with other women. Traditionally, women have been trained to seek happiness and fulfilment with a man. A feminist counsellor knows how insecure and vulnerable that leaves most women. In encouraging women to validate and like themselves as persons, to appreciate their own significance, she at the same time helps women to enjoy, respect, and seek out other women as primary friends and companions. A support network of women friends is seen as crucial in helping women to fully enjoy life and to reduce or eliminate emotional dependence on men.
- A feminist counsellor uses her own life experience—if relevant—to the consumer's life situation. The sharing helps to demystify the counsellor as omnipotent professional and to truly universalize, in a visible and concrete way, the struggle of human beings to survive and to change.
- Workers present themselves as imperfect human beings like the rest of us, not professional experts in a one-up/one-down relationship. It is a peer kind of relationship, with the focus necessarily concentrated on the user of the service. It is understood that without conscious, reciprocal learning between counsellor and consumer, there can be no authentic respect and trust in the tasks undertaken.
- Feminist counselling is concerned with political and personal questions arising from lesbian relationships. It is understood that lesbian women have to cope with a particularly virulent form of misogyny,

that the helping professions have most frequently perceived lesbian women as "sick." Lesbians often seek help in coping with the struggles and problems of being women in this society, of being couples, of "coming out," of being different. Feminist counsellors have the added advantage here of harboring few illusions about what heterosexuality means for women in a sexist society.

- With a feminist approach, there is a validation of women's life experience—as they tell it, as they feel it, as they react to it. The validation is a significant experience for women who have been denied such respect, dignity, and trust in a sexist society.
- There is recognition that, as with other oppressed groups, a key to regaining and retaining dignity, energy, and self-esteem is the anger that propels us to fight back and to join together in acting upon and changing our lives. Feminist counsellors encourage women to claim the full spectrum of human emotion, to refuse the demeaning labels attached to "unfeminine" behavior.
- It is recognized that women are especially deprived of nurturance. Traditionally, we do most of the nurturing, the giving, the domestic work, the childcare, the worrying. Instead of helping a woman to accept the primary caretaking work, the counsellor focuses on her central and essential needs and rights as a person. The consumer is not seen as adjunct to family, but as separate person, in relationship to the world at large, sharing and only sharing responsibility for caregiving and nurturance with men and older children.
- Feminist counsellors understand the enormous impact on women's lives of being required to provide daily care and nurturance to the young, the old, the sick, and the disabled. It is understood that such double standards must be overturned, that caring for others must be turned into shared tasks between women and men. Women are encouraged to actively and decisively assert their limits in relation to others, to refuse to be "superwomen."
- It is understood that marriage and motherhood, as options in life, are authentic choices for some women. It is also understood that other options are equally appropriate and, in this society, need support and reinforcement. The decision by a woman to be a solo mother, to remain child-free, to be lesbian, celibate, or sexual in ways other than the state and its institutions have defined, needs additional validation and support from a feminist counsellor. There is the assumption that there are many ways for women to love and to live.

- Girls and women have been systematically directed to the ideology of romantic love as the centre of our lives. Our resultant fear of aloneness and abandonment is a way of converting us into subordinates and nurturers of others. Feminist counsellors help women to see loving relationships as one part of life along with the central importance of developing other talents and possibilities.
- The consumer is encouraged to shop around for a counsellor before making a decision. In particular, the consumer needs information regarding the counsellor's views of women in society and whether female unhappiness and conflict is seen as "sickness." "Shopping" is a means for the consumer to assert control and make the decision in relation to seeking help, and sets the stage from the beginning for an egalitarian type of working relationship. She needs to be free to ask the counsellor about herself and her ways of working.
- A feminist counsellor is aware that girls and women have been trained to be "good" and "careful," meaning that we are made particularly wary and fearful of making mistakes and being penalized for them. This is a major source of disabling guilt. Women are instead encouraged to see life as continuing trial and error; past and present. There is active support for consumers trying out new ways of being, acting, and deciding—for women to claim the human right to fail, to move on.
- Girls and women are encouraged to seriously examine the structure of their mothers' and foremothers' lives. Given misogyny, most girls and women are taught to judge their mother's performance and experience very harshly, and in the process to set up opposite and impossible expectations for themselves. The mother/daughter connection is recognized as one that is damaged by patriarchy, yet potentially very rich.
- Feminist counselling attaches value to action, decision-making, and risk-taking. It is recognized that women have been taught to talk and react rather than to act, to be rather than to do, to feel rather than to decide—this in marriage as well as in traditional therapy or counselling (Chesler, 1971). Women are encouraged to act upon the problems facing them, individually and collectively.
- This approach highlights women's capacities to rediscover and reclaim the strength and power and talent that often lie dormant within us.

CONCLUSION

There is a marked tendency among helping professionals to see male violence as exceptional, outside the norm, connected with deviant behavior on the part of a minority of men. Bart (1986) warns us that violence against women—battering, incest, rape, sexual harassment—is "unexceptional" and ordinary rather than unusual in a sexist society.

I include economic violence (or exploitation) against women as unexceptional and ordinary. Here I refer to the well-known fact that women, solely on the basis of gender, earn about 60 cents for every dollar that men (on average) are paid, and that women, solely on the basis of gender, do more of the unpaid labor in and beyond the home.

Despite the continuing existence of such crimes and exploitation, there is powerful opposition to even considering women as an oppressed group. The definition intrudes on every woman's and man's existence. Mainstream counsellors and other helping professionals tend to mirror this opposition, to support the norms, values, and assumptions that underpin it.

This is partly why contemporary feminism as well as alternative counselling approaches have come into existence and have begun to make serious inroads into women's consciousness and lives.

Feminist counselling as a way of women helping women can be one significant link in moving towards change. It exemplifies the efforts of feminists to validate rather than to deny women's way of experiencing the world; to work together on women's oppression in its immediate reality; to help translate private, personal pain into public political issues. In connecting internal turmoil with external structures of oppression, feminist counselling becomes one tool, one resource for us in taking charge of our lives, individually and collectively.

Beginning to take back control of our existence as women is a continuing process and a potentially radical one. However, the important lesson to be learned in feminist counselling is that this process cannot be undertaken in isolation from other women, personally or politically. Gender is the fundamental issue that goes beyond all others. For until and unless women and men live equal, safe, and dignified lives as full adult members of society, free of violence and domination by men, there can and will be no fruitful coming together on any of the other critical social and political issues that haunt this shaky planet.

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WOMEN AND WORK: A Counsellor's Perspective

MARY K-HUGESSEN

Women come to counselling bringing with them a wide range of problems that run the gamut of human experience. Two-thirds of people who seek psychological help are female. One in three women seeks counselling, at some point in her life, as opposed to one in seven men (Wetzel, 1986). Women, when they come for help, often find it very difficult to be open about what the problem is. There are several reasons for this. They may really not know. They are often filled with guilt and shame for being inadequate and not coping as they should. Or they may be afraid of the consequences if they really address the issues in an honest manner. Therefore, women talk about symptoms of depression, fatigue, and unhappiness and physical problems such as headache and backache. They often seek help with relationships and significant affiliations. It is in this area of connectedness to others that women seem particularly vulnerable. Many women are convinced that they are stupid or abnormal. They talk about feeling as if they are going crazy.

Women are participating in different realms of life and in different kinds of jobs to an extent that they never have before. An advantaged few have made huge gains in the work world, but the vast majority of women work in dead-end, poorly paid, unfulfilling jobs (Miller, 1986).

Women have long played this subordinate role in a male-dominated society. According to Anne Schaef (1981), power and influ-

ence in North American society are determined by the White Male System that sets the rules. Every other group, including women, who make up more than half of the population, is in a disadvantaged position. Men and women interpret the world differently, but the institutions that describe the world, such as governments, universities, the church, and the workplace, are male dominated. Therefore, women hear the world interpreted in a way that does not match their reality. Thus they feel forced either to discredit their own perceptions or to challenge the accepted standard. In the first instance they feel incompetent or mad, and in the second they need a great deal of support (David, 1980). The negative forces that impact on women as a result of their subordinate position in society and their socialization process cause women a great deal of pain. Dysfunctional sex roles, the sexist bias of traditional therapies and of psychological and family theories, the physical victimization of women through battering, rape, and incest, and the feminization of poverty are but a few such forces (Wetzel, 1986).

Women who seek counselling usually have low self-esteem and poor self-confidence, poor communication and assertive skills, and unreasonable expectations of themselves, just as others have unreasonable expectations of them. To understand these dilemmas, a counsellor not only must recognize the actual problems that are being presented, but also must hear and understand the woman's perception of her situation in terms of society's values and her own socialization process.

This chapter will discuss some of the issues that should be considered when counselling women, such as the goals of the counselling and the skills the counsellor should acquire in order to help women attain these goals. Some stories of women will be presented in order to illustrate the types of problems women bring. In conclusion there will be a consideration of what issues need to be addressed by responsible persons in the workplace in order to help working women.

ISSUES IN COUNSELLING WOMEN

To help women it is important to recognize that traditional therapies not only were unhelpful but may even have been destructive. Phyllis Chesler (1972) describes a woman's relationship with her male therapist as a re-enactment of her relationship with her father, and as such it reinforces helplessness and passivity. She advocates women therapists for women. Indeed, there is more recent evidence that the attitudes held by female counsellors with regard to women's issues are

changing more rapidly than those of male counsellors (Davenport & Reims, 1978). When making a referral to a counsellor, Employee Assistance Program coordinators would do well to explore with the female employee the advantages of having counselling with a woman therapist.

When counselling a woman, it is important to work towards several goals.

First, it is essential to help the woman develop a sense of herself as being a whole person—one with a positive self-image and a clear notion of her strengths.

Second, it is desirable to help a woman develop the skills to take over the direction of her own life and not to live it in reaction to others (Russell, 1984). In doing so she must be helped to accept responsibility for her own actions, and to be assertive about her needs instead of trying to manipulate others to meet them for her.

Third, a woman should be encouraged to develop and express the repressed, or as yet unactualized, traits that are characteristic of male behavior so that she has a wider range of effective behaviors and responses (Pyke, 1980).

When counselling a woman the therapist should try to shift the emphasis from helping her adjust to the status quo, to helping her understand the situation in which she finds herself. In addition, the woman needs to acquire the skills and competence to change the situation into one that is equitable. The therapist is in a special position to facilitate change in a woman's experience, awareness, and perceptions of the world and her place in it (Russell, 1984).

This is a tall order and requires the development of certain skills on the part of the counsellor. A counsellor must be able to assure the woman that what she is experiencing is valid and to help her make sense of it (David, 1980). She must help her to understand the social, political, and psychological factors that contribute to her oppression so that she can restructure her world (Russell, 1984). She should help her to expand her repertoire of skills. Of tremendous benefit to a woman are referrals to self-help groups and groups that address assertiveness, communication, hobbies, stress reduction, and networking.

Another particularly effective technique when helping women is self-disclosure and sharing (David, 1980). It has several benefits. It

reduces the inequality of therapist and client positions by making the therapist less of an authority or expert, less distant, and more human. It enables the therapist to express feelings of empathy and compassion, and provides role modelling and feedback so that the client can see herself in a new way. The research shows that clients rate counsellors who share themselves during counselling more highly (VandeCreek & Angstadt, 1985). Finally, an effective counsellor must try to teach a woman to care for herself and her body.

Many women suffer a lot of physical as well as psychic pain. They suffer from headache, back pain, poor physical conditioning, dietary problems, and eating disorders. Education with regard to the issues of stress reduction, diet, and exercise are very important (David, 1980). When women are fit and relaxed, they gain a feeling of strength and control over their lives.

What follows are the stories of seven distressed women. These have been chosen in order to illustrate some problems that are typical of those experienced by many women. It is important for EAP counsellors, as well as counsellors in the community, to be knowledgeable in the areas of alcoholism and other addictions, incest, marital or other relationship breakdown, retirement, and stress. Although this list is not exhaustive of women's problems, it does cover a wide range of their experience.

SOME WOMEN'S STORIES

Alcoholism

Marie's Story

Marie was referred by her parish priest. She was a single mother of two boys and a girl between the ages of 9 and 14. She had recently received a promotion from a low management job to a highly visible position with a big increase in salary; this promotion was a term position. Also, she had recently lost a relationship with a man whom she liked very much. Marie drank at lunch time with friends and at home alone in the evening. She was able to talk about her dependency on alcohol but denied its importance. She was badly depressed. She was frightened that she was not competent to do the new job; she hated it, and wanted to return to the old one.

Co-Alcoholism: Joan's Story

Joan was referred by her EAP coordinator complaining of extreme depression and anxiety. She had been in treatment more than once but had experienced no relief of her symptoms. The astute EAP counsellor had discovered that Joan was

the adult child of two drinking parents; she felt a lot of anger towards them both. Joan was married to a supportive man, and had two children. She had a rather dull clerical job in which she knew she was underemployed. Joan's fear was that if she stayed in her present state of depression and anxiety, her husband and sons would suffer because she could not do for them what a wife and mother ought to do.

Co-Alcoholism: Lise's Story

Lise had been married for many years to an alcoholic husband. He had always been a drinker, and she and two children had always coped somehow. She was referred for help by a community health worker because she had lost the job that she had held for many years. When she came for help she was angry and very ashamed about what was happening to her. She had been told by her former place of employment that she had lost the ability to function adequately enough for them to continue to employ her. She was angry at her husband and desperately afraid that he would be fired, or could even die from his drinking.

Discussion

Marie, Joan, and Lise were all suffering from alcoholism, their own or another person's. They were all depressed, angry, anxious, ashamed, and isolated. They suffered from low self-esteem, passivity, and an inability to recognize and ask for what they needed. They had all fallen short of their deeply instilled desire to look after others properly and to be perfect themselves. The pain for them all was intense.

Women who suffer from alcoholism (their own or another's) appear in significant numbers in counselling offices in both the workplace and the community. Counsellors are often reluctant to get involved in treating alcoholics and co-dependants, because alcoholics are difficult and unrewarding clients (Googins, 1984). It is possible that counsellors still fear to ask basic questions such as "How much do you drink?", "In what circumstances do you drink?", "What happens to you when you drink?" (Corrigan, 1980; Lester, 1982). It is important to find out who else drinks, how much, and in what circumstances. The seriousness of the drinking of others is often downplayed or denied by a female client. The fact that someone for whom she is responsible is drinking may provoke a sense of shame and failure in her. In the case of the adult daughter of one or more alcoholic parents the hurt runs very deep. It may be a slow and tearful process for such a woman to begin to deal with all the emotion and to help herself constructively.

Alcoholism issues will have affected all aspects of a woman's functioning by the time she presents herself for help. Women therapists, women's treatment centres, and women's supportive groups are all proving to be effective and safe places for women to receive help (Habib & Landgraf, 1977). Nevertheless, women still feel more stigmatized than ever when they are addicted; condemnation by society, inadequate diagnosis, and lack of support in finding appropriate childcare all present formidable barriers to recovery (Sandmaier, 1980).

Sexual Assault/Incest

Josée's Story

Josée, a pediatric nurse aged 35, came for help because she was aware that she was functioning poorly in many aspects of her life. An intelligent, well-educated, and insightful person, she found herself feeling depressed, trapped, and angry about her dependence on her husband and their inability to achieve the level of intimacy she wanted. Josée was significantly overweight and would binge on sweets. She had two young girls of whom she was extremely overprotective.

Early in the counselling sessions, Josée talked for the first time of her older brother, who had had a sexual relationship with her from when she was 8 until she was 11. Her mother had refused to believe Josée when Josée told her about it many years later. Josée's father, whom she had adored, died when she was 10.

Discussion

All counsellors should assume that they have, in their caseload, survivors of incest and sexual assault. Some clients are afraid to reveal their stories because they fear the counsellor's disapproval. Others have truly blocked the memory and their feelings. It often takes gentle and sensitive investigation over some period of time to help a woman uncover her awful secret. Instances of sexual assault and incest are underreported. Counsellors should ask about such incidents, not avoid the issue. When they do ask, they may be alarmed to discover how many women reveal such experiences. Some women report repeated experiences with different men.

Colao and Hunt (1985) state that sexual assault is the extreme enactment of "male" and "female" roles as they are learned in this culture. The frequency with which sexual assault occurs would suggest that there will never be an end to it until the damaging

polarity between what is considered male behavior and female behavior is eradicated. The sexual nature of the assault or incest, the violence of it, and society's negative attitudes about women, sexuality, and assault mean that women are subject to unique problems not faced by victims of other traumatic events. They often are blamed for what happened. Very often this blame is internalized and leads to reactions of fear, isolation, mistrust, depression, guilt, and, above all, rage and shame (Courtois, 1979). The incest survivor must be helped to express her anger both at the violator and at the parents who did not protect her. She needs to channel her anger constructively in a way that will not be harmful to herself and others (Faria & Belohlavek, 1984).

Counselling plays a very important role in helping sexual violence victims. As every woman responds differently, it is important to tailor the counselling to her needs and to proceed at her pace. Lack of trust is a key element for these women. The goal of the counselling is to help the survivor get control over her life. She must make her own decisions. A very helpful procedure is to refer her to a centre where she can receive counselling from another survivor of sexual abuse. In some cases group treatment may also be helpful (Deighton & McPeek, 1985). Concurrent with that, the original counsellor can continue to help with changes that need to be made.

Loss

Mary Louise's Story

Mary Louise was a 31-year-old woman, mother of three young children, a physiotherapist by occupation, who had been married for nine years to an alcoholic. Her husband, John, had been dry for the past four years. He had been married previously and had two children from that marriage. The present marriage was extremely troubled. John was given to temper tantrums and could be quite frightening when enraged. Mary Louise was afraid of him and unable to speak up in his presence. She was passive, depressed, overworked, and exhausted. The marriage had limped along for years. Mary Louise requested marriage counselling because she loved John and wanted to "put their marriage back together."

A joint interview revealed that John did not love his wife, he found much fault with her, he wanted to come and go as he wished, but he nevertheless wanted to live at home and be married. The couple were deeply in debt, in spite of the fact that John had a very good salary. He spent a great deal of money, and Mary

Louise and the children were given very little. Mary Louise felt that she was not able to work because she did not want to leave the children. John refused help, and Mary Louise, after three months of counselling, filed for separation.

Discussion

Many women who are now divorcing grew up with the idea that marriage is forever, the ultimate ideal goal that would provide a lifetime of security under the protection of a powerful mate. When the reality turns out to be somewhat different and the marriage ends, the experience is shattering for them. The problems that they face are those of autonomous functioning, financial hardship, and loneliness. Women have been taught to regard themselves as the weaker and less decisive partner in a relationship. Learning to function independently is so difficult that some women will try to avoid this work and will concentrate on seeking out a replacement, in some cases repeatedly (Russell, 1984).

A sense of loss, real or threatened, is experienced by a large proportion of women who come for counselling. These women feel that aloneness is synonymous with loneliness, and loneliness heads the list of what women fear most (Booth, 1983). Whether because of divorce, death, or children leaving home, women see being alone as deprivation and abandonment (Greenspan, 1985). Socially, lone women experience serious limitations and ostracism. Even in the company of children and other women, a woman in our society is perceived to be, and feels herself to be, alone.

For women who have lost a relationship through divorce there is a tremendous feeling of failure at not having succeeded at their most important role in society. Because of women's need for connectedness and affiliation, this loss is akin to total loss of self (Rawlings & Carter, 1979). Women need a counsellor's help to rebuild their self-esteem. Participation in a group with women who are also going through separation and divorce can be invaluable. The counsellor must also help the woman to let go of the relationship. In order to do this, the woman must be able to deal with her anger. Because women have been discouraged from expressing anger or aggression, they may be experiencing

the emotion as rejection, hurt, guilt, or depression (Rawlings & Carter, 1979). The work can be slow. It may take from two to four years for a woman to begin to feel whole. Like grieving, it is work that must be done to achieve good mental health.

Retirement

Clara's Story

When Clara, age 59, was referred for help by her EAP coordinator, it seemed that she had already made up her mind about what she wanted to do. Clara had worked for the same employer for 20 years, and before that had been steadily employed since the age of 18. Clara had never married and had lived with her mother until the latter died. She had several good women friends. At the time she was referred, Clara had been on sick leave for two months because of severe back problems and a recently developed case of hives. Her doctor, an elderly man, had refused to continue signing her medical absence certificates, saying she was fit to return to work. When she came for her counselling appointment, she had been too disabled to fasten her brassiere or put on her panty hose. She was very angry and frightened because she felt that she was absolutely unable to work.

Things were also bad for Clara at the workplace. She had a job as a clerical typist and had not had a promotion for some years. She was in a constant state of disfavor with her male supervisor, who talked to her very little and had a patronizing attitude when he did address her. By this time, she had very few meaningful relationships remaining at work. Everything seemed to be going downhill for Clara. She felt that her supervisor wanted a worker who was trained on word processors. She was depressed, anxious, and angry. She wanted to retire, but she didn't know if she could or if that was the right thing to do.

Discussion

Like Mary Louise, Clara was also facing a potential loss. Retirement does mean a severe reduction in income, and can mean a loss of important social contacts and a sense of usefulness and purpose. It is important to realize that retirement means different things for people depending on several factors. Very little has been written about retiring women, how they reach the decision to retire, and how they fare subsequently. The concept of work and retirement is difficult in relation to women because the whole notion of the meaning and definition of work has been largely shaped by men (Connidis, 1982).

It would seem that the decision to retire is mainly based on two

considerations: the state of health and the projected retirement income (Gratton & Haug, 1983). In general men and women both adjust well to retirement. The small proportion of female retirees who report dissatisfaction in adjusting tend to have poor health and financial worries. Because older women are more likely than their male counterparts to be poor, they express more negative attitudes towards retirement (Gratton & Haug, 1983). For a woman who married and entered the workforce late or held only part-time jobs, the prospect of retirement with inadequate pension and potential widowhood is frightening. For a single woman, the factors she has to deal with may be different, but the chances are that she too, because of low-paying jobs or poor benefits, may not be well provided for financially.

Pre-retirement planning for women is an area that has been very much overlooked (Safford, 1988). Helping a woman to decide about retirement, to plan for it, and to adjust to it satisfactorily is very important work for a counsellor. It is necessary to help her look at as full a range of options as possible. She needs to know what her financial situation will be and to develop appropriate budgeting and investment skills. Her living arrangements should be reviewed in view of her finances, but also in the light of issues of companionship, easy travel, and a host of other considerations. She may need to look at developing some new skills for hobbies or for part-time work to augment her pension and keep her fulfilled. She may need new group contacts, social contacts, or support services. It is very important not to make assumptions about how a woman will fare after retirement, but to listen to her plans and desires and to guide and support her as she puts in place the best possible arrangement for herself.

Stress

Allison's Story

Allison, a legal secretary, came for counselling complaining of extreme depression and anxiety at times bordering on panic. She had been prescribed antidepressants but had experienced no relief. She had been talked into again seeking help by her husband's employer because Allison's husband, Bert, was complaining that he was so stressed by his own work and his wife's behavior that he was becoming ill.

Allison and Bert had three children, one of whom had multiple sclerosis and required a lot of medical and home care. Another child was diabetic. Allison had

the children enrolled in Brownies and Beavers. She had aging parents who needed her time as well. Bert did share the household tasks with her. Allison's work demanded that she sometimes put in overtime. She had to share a car with her husband because he felt that they could not afford a second one. Bert was given to bouts of anger and the cold shoulder treatment. He felt that his wife was a poor manager and a slovenly housekeeper, and he criticized her a lot. Allison felt unsupported at home and frantically pressured at work, and acted as if she was trapped and victimized. She could not speak up for herself for fear of angering her husband.

Discussion

Even though more and more men are sharing household tasks and helping with children, women still retain the primary responsibility for the immediate and extended family, and for social relationships. Hence they have two or more jobs. The majority of women work in poorly paying, dead-end blue-collar and clerical jobs. They also must work in situations that implicitly assume there is a "housewife" at home. The workplace is structured by men and has made few accommodations for the needs of working women. Childcare is scarce and expensive. The combined workload of two jobs, poor wages, few if any benefits, and virtually no chance of mobility, with an inadequate pension at the end of it all, mean a life of unremitting toil and inadequate rest. The fact is that our society does not see the work that women do, in the private and family spheres, as "work." The extent of emotional, physical, and sexual demands that are incurred in keeping husbands going, raising children, and housekeeping is seen as "the natural labor of femininity—and therefore, non-remunerative by definition" (Greenspan, 1985). What women do the best of all has no value.

> The woman who seeks to actualize the feminist ideals of today confronts an economic system unwilling to make changes that would allow for greater accommodation between the workplace and the family and continues to make women pay the cost. (Greenspan, 1985).

Outcomes

The goals and skills of feminist counselling were used in order to help the women whose stories were told above. Marie, Joan, and Lise, the sufferers from alcoholism, all improved with regard to their feelings of independence, autonomy, and personal effectiveness. Marie was

referred for treatment, at her own request, to a women's treatment centre. She attends Alcoholics Anonymous regularly. She has much more self-confidence, is functioning well in her new job, and is loving it and the extra money it brings her. She also has a new relationship with a man. Joan and Lise are happier. They both attended Alanon as well as an intensive family program for family members of alcoholics, and Joan also attends meetings for adult children of alcoholics. Joan is able to talk to her alcoholic and co-dependent father without feeling angry and guilty. She is better able to detach herself from her alcoholic mother's problems. She has returned to university to upgrade her skills in an effort to find more rewarding work. Joan, her husband, and her children are more comfortable with one another. Lise is studying also. She is determined to add to her former work experience in order to relocate herself professionally. She also has become less angry about her alcoholic husband's behavior, knowing she might have to separate from him. She is more self-attentive.

It was a long time before Mary Louise could come to grips with her loss. Her loneliness, fear, and poverty combined to make her very negative about life. Counselling over a two-year period, treatment in an alcoholism family program, participation in a group for separated and divorced persons, and extensive assigned reading all helped her. Self-disclosure of the therapist, social analysis, and being in touch with a network of other women has made her much stronger. Mary Louise now has a job, has moved to a better location for her and the children, and is functioning self-confidently.

Clara did retire. She found that she had enough holiday, sick leave, and other rights to cover her until age 60. She worked out in detail what it meant to take a pension at that age. She also made plans to study some of the new office technology so that she could get contract and occasional employment through a seniors' employment office. She has a network of friends and has plans to travel. She plans to join a back-care and fitness group at the YWCA. She has changed doctors and has found one who does counselling as well as practising holistic medicine. Clara was luckier than many women because she had a good pension scheme. She is thrilled with her choice to retire.

Josée, the victim of incest, needed much self-validation and support to leave her victim role and channel her anger constructively. She was helped immensely by peer counselling with another incest survivor. She also received help from Overeaters Anonymous. She has

plans to return to university to do a master's degree in nursing and is hoping to take up an administrative position. Always a feminist, Josée wants to be active in helping to improve the work situation for nurses.

Finally, Allison embodies so much of what women feel. In a bygone day she would have been diagnosed as a "hysteric." The headaches, panic, and depression would have confirmed a secondary diagnosis of "inadequate personality." Allison was counselled at regular intervals for one and a half years. She came to accept that she had choices about how to lead her life. She learned to ask her extensive family for support, she took courses in self-esteem and assertiveness at a community college, she used a small inheritance to buy a car to increase her ability to plan for her own and her children's activities. She is taking night courses to upgrade her skills and has started a small typing business at home to augment her income. Always very active, Allison has channelled her efforts more constructively so that she is more independent and autonomous. Her husband is not supportive of her efforts and Allison knows that her marriage may not survive these changes. She is still stressed, but her symptoms are relieved and she has a new sense of confidence and hope.

CONCLUSION: SOME IMPLICATIONS FOR EMPLOYEE ASSISTANCE PROGRAMS

It is clear that working women experience difficulties for which they seek help. They come forth in quite significant numbers. Sometimes these women can be specific about what is wrong; often they cannot. Sometimes they are specific about what a problem is, but come to see that the problem is really something else. In short, the picture can be very confused. As women seek help with problems, it becomes easier to identify and classify what features of a particular organization are stressful to them. Thus, issues of lack of mobility, clustering of occupations, working hours, and pension and other benefits can be addressed. EAP personnel can also select topics such as drug dependency, physical fitness, pre-retirement planning, and good parenting as the subjects of seminars and workshops. Women, if asked, could surely add to that list. A presentation on how to access EAPs, and an explanation of how they work, would be useful for women.

It is important for counsellors in the workplace to proceed slowly, carefully, and with compassion. An attempt to do the traditional thing, to tell women that they must adjust to the status quo, will confirm their feelings of powerlessness. Women must feel that they are under-

stood and respected or they will not trust a therapist or themselves enough to work for change. It might take considerable time and patience, even up to a year, to motivate a female employee to accept a referral for outside counselling. Also the issues must be clear so that the referral is a suitable one. Thus, a workplace counsellor, male or female, must be well acquainted with women's issues, must be able to analyse the problems from a feminist perspective, must be able to validate the employee and give her feedback and support, and must teach and care for her until she can begin to gain insight about the direction in which she wishes to move and the motivation with which to begin. Only then is the woman well prepared for referral. It is essential, also, that EAP counsellors know the resources in the community and establish links with the ones that are frequently used.

EAP coordinators work within the organization and are in a position to understand how it works and how to influence it. As they try to identify the sources of stress for women, they may be in a position to change the work environment. The obvious problem here is that the main preoccupation of the workplace is the bottom line of profits, and the main preoccupation of the EAP counsellor should be his/her employee/client. Given that the organization pays the counsellor's salary, it can be a sensitive and unsatisfactory situation. Seminars that deal with the issues of traditional and rigid work hours, poor supervision, communication problems, inadequate daycare, and unfair promotion procedures among other topics are vitally important to raise consciousness levels and to teach women. The EAP coordinator is not only a counsellor; he or she is also an educator, an advocate, and an activist (Gettman & Pena, 1986).

The workplace, which is organized by men, is a major source of stress for women. For women, the concept of connectedness is an integral part of their being. Therefore, the organization of work and the workplace cannot be separated from concerns about social relationships with employers, supervisors, and co-workers. Organizational issues, such as the division of labor and power relationships, pay disparity, attitudes towards women, and differential exposure to workplace materials, are all stressful (Gettman & Pena, 1986).

Counselling must seek to help women to meet their needs in all relationships in the workplace, in the family, and in the community, without destroying those relationships. Implied in this statement is the notion that work done with women must try to change the social order,

which is currently damaging to them, to one where each has personal power and no one sex, race, religion, or culture has power over another (Wetzel, 1986).

Finally, EAP counsellors, and others who work with women, should be encouraged to document and evaluate their work in order that a practice-oriented scholarship about women's issues can be built up and shared (Quam & Austin, 1984). Knowledge of women's issues has increased over the last decade. It is essential to keep up the momentum!

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INNOVATIVE WORKSITE PROGRAMS FOR WOMEN

WIFE ABUSE: A Worksite Pilot Project

GLENN WOLFSON

This article describes an innovative pilot project developed by the Regional Municipality of Ottawa-Carleton (RMOC), Ontario, Canada. Funding was provided by the Ontario Women's Directorate (Attorney General's Department) and the Regional Council. The project is called "Wife Abuse: Education in the Workplace."

PROJECT SETTING

On January 1, 1969, the Regional Municipality of Ottawa-Carleton, consisting of 11 municipalities covering an area of 2,757 km^2, was formally created by an Act of the Ontario Provincial Legislature.

When Ottawa-Carleton was created, functions common to all of the member municipalities were transferred from local to Regional control, together with staff needed to perform those duties. Among these functions are water supply, sewage treatment, public transit, social services, health unit, homes for the aged, and economic development.

At the time of this project the Region employed approximately 3,857 people, 90% of whom are represented by five separate staff associations.

Female Employee Representation

Data from the payroll system revealed that in 1986 the total corporate workforce consisted of 2,209 women and 1,648 men; thus 57.3% of the RMOC workforce was female. Three of the largest departments (Homes for the Aged, Social Services, and Health) are predominantly female, and the two other large departments (Transportation and Environmental Services) are mostly male.

Women are concentrated in three main groups: professional (e.g., nurses and social workers), clerical (e.g., administrative assistants and clerks), and service (e.g., attendants and daycare staff).

There are more men than women in all three management groups; and, although there are slightly more female than male supervisors, the groups they supervise (primarily clerical and service) are almost entirely female.

In 1986, female employees of the RMOC earned approximately 79.6% of male earnings, an annual average of $29,250. Women in all occupational groups earned less than their male counterparts. Of course, this ratio differs for each department and occupational group.

Related to this wage gap is the fact that proportionately fewer women than men have full-time continuous positions at RMOC. Only half (54.5%) of the female workforce work on a full-time continuous basis, whereas three-quarters (78.6%) of the males have full-time continuous positions.

Employee Assistance Program

The Regional Government started an Employee Assistance Program (EAP) in 1982. It was developed jointly by management and unions to aid employees with problems. An in-house coordinator and part-time counsellor oversee program activities. The EAP service covers a broad range of problems and has been well utilized by staff at all levels.

PROJECT BACKGROUND

In March 1985, the Executive Committee of Regional Council asked that the Commissioners of Personnel and Social Services prepare a report recommending a pilot project to provide support services to employees of the RMOC who are victims/perpetrators of wife assaults.

In May 1985, a Carleton University student (MSW program) agreed to a field placement within the EAP office. She and the EAP co-

ordinator began to develop a pilot project that would ultimately be based upon a solid employee needs assessment.

PROJECT PHASE ONE

The initial phase of the pilot project included: (1) a detailed literature review, (2) consultations with experts in the field of wife assault and family violence (e.g., the National Clearinghouse on Family Violence within Health and Welfare Canada, the Psychology Department of Carleton University, the Social Services Department of RMOC, and the Ottawa Task Force on Wife Assault), (3) a search for existing worksite programs, and (4) the identification of employee needs, concerns, and preferences.

It soon became apparent that there was very little being done in the workplace to deal with this complex issue of wife assault. The subject of wife assault is a delicate issue, often considered a taboo subject and rarely discussed. The first step was to educate and sensitize employees. It was important to sensitize employees to the general issue and also obtain their feedback regarding their needs for information and possible assistance. Therefore, a combined brochure and questionnaire was designed and sent to all Regional staff. Their feedback was very positive: a number of victims and perpetrators came to the EAP office for help, and numerous employee calls were received for more information on the subject.

It was found that ongoing supportive counselling was and is an essential service for abused women. A common need emerged, from the comments of victims and of worksite health care professionals alike, for a service that would provide them with knowledge on the issue and ready access to the appropriate resources when required. Further, additional information on the subject was deemed essential for all employees. The following are some of the comments received from employees who are victims of wife assault:

- "...lack of knowledge, unsure what to do..."
- "...never felt that I deserved to be helped– didn't know where to go–was ashamed..."
- "...help is only adequate and depends with whom you connect..."
- "...[I felt] shame, fear of my husband losing his job [if I sought help]..."

- "...resources not easy to obtain..."

In general, these battered women indicated a lack of knowledge, fear, and confusion in their attempts to seek assistance. Also, it was found that the nature and extent of the abuse recorded varied considerably from one situation to another: from psychological abuse to physical abuse; from occasional to repeated incidents; from recent to long-standing problems.

PROJECT PHASE TWO

There was a need for the organization to respond systematically to this serious social problem — one that held major implications for the workplace. RMOC's action included the following six steps:

Step 1—Funding

Concurrent with the Region's interest in a demonstration project, the Attorney General of Ontario announced the province's commitment to this problem in a campaign referred to as "Let's Break the Silence." Limited government funding was being made available to individuals and groups who met certain criteria — mainly to assist community-based initiatives that would benefit the women of Ontario. A proposal was developed by RMOC, expanding upon the work already done in this area, and was sent for consideration to the Ontario Women's Directorate in February 1986. This body was overseeing such applications on behalf of the Ontario government.

In October 1986, funding in the amount of $24,000 was approved for this project by the government of Ontario. Also, Regional Council supported this project by contributing an additional $6,200.

Step 2 —Workplace Advisory Committee

In January 1987, a Workplace Advisory Committee on Wife Assault was established, and consisted of 14 volunteers from within the Region. The committee met seven times during the course of the project to discuss such topics as methods for program implementation, a name for the project, marketing ideas, strategies around attendance, workshop design, the timetable, and the ongoing role of the committee. Members of the committee attended a pilot training workshop and provided comments and constructive criticism of the content and format.

The committee proved to be a valuable resource that made for realization of project objectives and facilitated communication regarding

the workshops. In addition, the committee representatives responded to any project problems by working closely with the project consultants and the EAP coordinator.

Step 3 —Project Goals and Objectives

The main goal of this project is to provide an opportunity for all employees, male and female, to become better educated about the issue of wife assault and to learn about worksite help that is available to victims/perpetrators, and to facilitate timely referral for assistance.

Observations underlying this project include:

- In an employee base of 4,000, a significant number of men and women will be involved in abusive relationships—1 in 10 women is a widely used statistic, although more recent data estimate the figure to be 1 in 5.
- The better that people are educated to the complex and traumatic nature of wife assault, the more understanding and supportive those people can be to individuals who wish to seek help to end the violence in their lives.
- Individuals seeking help to end the violence in their lives are more likely to do so if the environment in which they work provides a supportive non-judgmental atmosphere.

The Workplace Advisory Committee identified seven project objectives as follows:

- To heighten awareness among Regional employees at all levels of the issues surrounding wife assault.
- To train key departmental personnel in various ways to identify signs of abuse and to offer appropriate assistance to victims and perpetrators.
- To develop a manual and a display of resources for the EAP unit that would provide direction for short-term counselling needs and a list of community resources available in the Ottawa-Carleton area for victims and perpetrators.
- To provide Regional employees with a well-developed resource system that would help them deal with this problem on an ongoing basis.
- To evaluate the effect of heightening awareness among employees in the work setting about the issue of wife assault.

- To make employees more aware of the services that the EAP provides.
- To prepare a final report outling all activities of this pilot project.

Step 4 —Program Implementation

The following outline, extracted from the original project planning document, gives a brief description of the program's implementation events:

- Two consultants in the area of wife assault to be hired (male and female).
- Select and sensitize an advisory committee to: set targets; develop strategy; develop evaluation tools.
- Locate and prepare required resource materials for workshops.
- Design training manual: display materials; interview referral resources in Ottawa.
- Establish a timetable for training sessions.
- Lead workshops specifically designed for different workforce target populations:

  A. Senior Management: sensitization to issue, extent of problem, myths, impact upon workplace; need of workers living in abusive situations to seek and follow through on help available in the Region; policy implications.

  B. Supervisors/Middle Management/Union Representatives: sensitization to issue, impact upon workforce; how to identify; needs of victims; appropriate action, ways to support.

  C. Employees: sensitize to issue, dispelling myths, extent of problem; information on types of help available, how to get help.
- To develop a plan to ensure this service is continued for Regional employees.
- Evaluation of the project.
- Final report and "how to" manual for the Ontario Women's Directorate, also to be provided to other organizations who are interested.
- Possible workshop for organizations that have expressed an interest in this issue.

Step 5—Program Evaluation

Pre and post questionnaires were distributed to staff, selected at random, to measure for increase in knowledge and/or change in attitudes. Also, caregivers in Ottawa-Carleton were made aware of this project and asked to record any referrals that may have been generated from the project. The EAP office also noted any changes in referral trends. Various teaching modes and styles were documented. Also size of groups, gender, and overall group dynamics were observed and noted. Sessions were given in English and French. All educational sessions were evaluated by the participants.

Step 6—Program Outcomes

Between June 1987 and July 1988, the EAP coordinator with the assistance of two counselling specialists managed a project that brought information about wife abuse to 700 Regional employees. A workshop lasting approximately two hours was presented in 30 sessions to a major segment of the workforce. Participation was voluntary.

Workshop sessions provided an overview of the issue of wife abuse, with some explanations about its causes and dynamics, and provided information about how to help victims and abusers get in touch with local resources. The implications of the wife abuse issue for workplace managers were also highlighted.

Conclusions drawn after the implementation of this successful series of workshops indicate that:

- Participation on a voluntary basis in an in-house training program about wife abuse confirms interest and motivation to learn on the part of almost half of eligible workers.
- Workshops about wife abuse are of interest to employees in a variety of work settings.
- Workshops about wife abuse presented in the workplace can enhance the learning of the general population.
- An informal and relaxed discussion format is preferable to a structured lecture presentation.
- Learning from workshops about wife abuse can lead to changes in attitude towards the victims and their batterers.

Recommendations to other worksite managers are outlined and specific recommendations leading to an ongoing and enhanced wife abuse prevention program are targeted at the RMOC.

Employees are now talking about the problem and know where to get help if it is required. Feedback from employees and from community social and health agencies has been very positive. Also other employers from Canada and the United States have expressed a keen interest in this project.

GENERAL OBSERVATIONS

Wife assault is a fact of life for many women in Canada and the United States. Statistics in both countries reveal that this problem has reached overwhelming proportions. As noted, 1 in 10 Canadian women is beaten by her partner. This proportion is slightly higher in the United States. The partner is responsible in approximately 60% of all murders of females in Canada. Wife assault happens to women of all income and educational levels, in all religious and ethnic groups.

Wife assault is certainly one issue that has negative consequences both at home and on the job. With the human suffering—both physical and emotional—absenteeism increases, productivity decreases, and morale problems increase. For example, an abusive partner may harass a spouse at work by appearing at work or by tying up the worksite phones in the hope his partner will lose her job and become more dependent upon him.

Reaching abused women can be a demanding task because of the very nature of the problem. "Wife assault remains a private issue, and the pressure to keep it within the family is compounded by the lack of money and concrete and comprehensive services—keeping women isolated within their situation" (Wolfson & Irving, 1986).

Help in the Workplace

EAPs can effectively reach out to working women at the worksite. The past 20 years have witnessed a dramatic and steady increase in the numbers of working women. At the Region, as noted earlier, 57% of the workforce is female, employed primarily as nurses and social workers and in the clerical and service fields. As more women enter the workforce, EAPs and related health promotion programming in the workplace can provide an excellent opportunity for helping victims of abuse.

One key way to reach abuse victims and sensitize all staff to the issue of wife abuse is through education—especially of supervisors.

The Supervisor's Role

The supervisor can play a unique role in helping abused women.

Supervisors are in constant contact with their staff and are often confronted with the personal problems that impact on the workplace. One of the first tasks for the supervisor is to identify the problem, which is often very difficult. Employees will often cover up for others who are experiencing problems.

It is important for supervisors to be attentive to serious changes in a woman's behavior or her work pattern. Is she depressed or extremely nervous? Is she receiving an excessive number of phone calls? Is her work deteriorating? "If she goes so far as to share her fears with her employer it can mean the partner's threats and violence are not only occurring in the home but that she cannot feel safe at work either" (T. Davidson, 1984).

High absenteeism is often associated with wife abuse. Battered women may be waiting for the physical or emotional signs of abuse to heal before returning to work. "Knowing these signs can assist the supervisor in early detection of this problem and can ameliorate a potentially hazardous situation for all concerned" (Wolfson & Irving, 1986).

It is important that the supervisor not attempt to be responsible for counselling but rather recognize the signs of abuse, offer protection within reason from intrusion on the job, and refer the victim to the EAP or any other service for battered women. With the proper intervention, the abused woman and in some cases the perpetrator will receive the help they so desperately need.

CONCLUSION

This workplace educational initiative has made Regional staff more aware of the complex nature of wife assault. More important, employees — both abusers and abused — are using the organization's EAP service in greater numbers. The solution to the problem, however, will require the joint efforts of community, government, employers, and workers. All of us must be involved.

Further information on this innovative project may be obtained from Glenn Wolfson, Employee Assistance Programs Coordinator, Regional Municipality of Ottawa-Carleton Employee Health Service, 3rd Floor, 222 Queen Street, Ottawa, Ontario K1P 5Z3.

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SPECIAL WORKSITE PROGRAMS: One Company's Experience

JANICE INNISS

The purpose of this article is to present information on worksite programs developed to enhance wellness that are currently in place at the Canadian Bank Note Company (CBN), Ottawa, Canada. An effort will be made to describe the origin, content, and implementation of these programs and evaluate their effectiveness. Wherever possible, it will be indicated how male and female programming needs differ or are similar in this particular worksite.

WELLNESS

The concept of wellness is perceived as an ongoing continuum or the movement towards an increased awareness of one's self and the environment (Clark, 1986). The goal for each individual is optimum functioning: physically, psychologically, and socially. The achievement of optimum wellness may involve behaviors related to nutrition awareness, stress management, environmental sensitivity, interpersonal relationships, fitness enhancement, self-care responsibility, and the like (CBN, 1986; Clark, 1986). Now, and in the future, the worksite can be an ideal place for wellness programs—health screening, education intervention, and prevention services (AAOHN, 1987).

THE COMPANY

The worksite described in this article, a single-site plant, is a Canadian-owned security printing company providing a wide variety of

security documents, nationally and internationally—stamps, bonds, and currency.

The company employs 369 full-time workers, 201 male and 168 female. Approximately 70% of the workforce is unionized; these workers are represented by five international unions, with eleven collective agreements. Of the middle and senior management, 13% are women.

At this worksite heavy machinery is used and materials frequently moved from one area to another. Several physical and chemical hazards are present in the work environment such as noise, dust, and solvents and other potentially harmful chemicals. Repetitive movements and limited activity are characteristics of certain tasks (CBN, 1986).

The printing industry is cyclical in nature with high and low periods of productivity. This plant reflects that pattern.

On-site health services to employees have been in place since the early part of the century. The health services staff consists of one full-time registered nurse, who has additional education in occupational health and employee counselling, and a part-time consulting physician. The latter is responsible for medical directives, employment medical examinations, and other services as required. As well, field placement experience in occupational health nursing is provided for postgraduate nursing students.

WOMEN WORKERS

Working women at the CBN have needs similar to working women elsewhere. In a recent survey (CBN, 1987), they identify higher stress levels than the male workers from both time-related pressure and human relations difficulties as well as lack of control over their work environment. For women, work and family represent two major sources of emotional distress. Problems in either area (family demands on time and emotions, or pressure derived from the workplace such as unscheduled overtime or environmental and interpersonal working conditions) express themselves in stress-related symptoms such as anxiety, depression, eating disorders, and high blood pressure, and in higher absenteeism rates than their male counterparts (CBN, 1986).

HEALTH PROGRAMS

In the past six years, several worksite wellness programs have been implemented at the CBN based on the identified needs of employ-

ees. Programs currently in place focus on back care education, blood pressure screening and monitoring, smoking cessation, weight control and nutrition, and an Employee Assistance Program.

Back problems affect four out of five persons between the ages of 20 and 60 years. Half of these problems occur at work and are a leading cause of Workers' Compensation Board claims (Schneiderman, 1981). In 1982, it became apparent that the number of back injuries at the CBN resulting in lost time from work were a serious problem because of the frequency and the repetitive nature of the injuries. A one-hour Back Care Education Program, which followed Workers' Compensation Board guidelines, was introduced to educate workers about the causes of common back problems, the structure and function of the spine, and workers' preventive lifestyle practices including posture, exercise, body mechanics, and adaptation to worksite demands. The presence of an on-site health practitioner allows follow-up of workplace concerns, identification of ergonomic issues, and the provision and reinforcement of educational information. In addition, the employment physical examination includes a back strength assessment for employees with a history of back problems or job requirements that include lifting.

Blood pressure monitoring at weekly, monthly, or quarterly intervals has been in place since 1975 for a group of known hypertensive employees (approximately 30 at present) at their own or their physician's request. The frequency of monitoring varies, depending on stabilization of blood pressure, compliance with the prescribed medical regime, and recommended lifestyle changes. Normal average blood pressure reading is 120/80; blood pressure readings below 140/90 reduce the risk of developing coronary artery disease and associated mortality (Johnson & Lundgren, 1988; Schneiderman, 1981).

Blood pressure screening in the workplace was begun in 1983. Regular screening is particularly important for those who have a history of elevated blood pressure or a family history of heart disease, hypertension, or stroke (Schneiderman, 1981). Initially, workers were invited to visit the Health Services Department during Heart Month (February 1983) for blood pressure screening. Because the response was low, subsequent screening has been scheduled in individual work areas. If three separate readings reveal a pressure higher than 150/90, medical referral is recommended.

Cigarette smoking, an activity of 5.5 million Canadians or 28.8% of the population over 15 years of age, is the single most preventable

cause of death in North America (Health and Welfare Canada, 1988a,b; Schneiderman, 1981). At the request of several employees, on-site smoking cessation classes have been held annually since 1984 to coincide with National Non-Smoking Week and Weedless Wednesday. Seven half-hour sessions are held on employee time (before work, during lunch, or after work). The program assists participants to understand smoking addiction—physical, social, and psychological dimensions; to anticipate problems associated with quitting; and to share group support in planning to quit as well as during the actual quitting process. Further, the company is in the process of considering a non-smoking policy for the worksite.

In 1985, approaches were made to Weight Watchers International to present their program at CBN; however, enrolment failed to meet the required number (20) of participants. Nevertheless, 13 interested employees decided to establish a mutual support group with the nurse as leader. This group continues to meet weekly for a brown bag lunch on employee time. The program consists of the provision and discussion of print material related to diet, nutrition, and weight control exercise; a weekly weigh-in with individual counselling; and group support for concerns and problems with weight control.

EA programming has been a focus in recent years. In 1985, after several years of discussion and planning—first by the company Health and Safety Committee, then by a group of concerned employees—the CBN EAP was launched. The CBN EAP is a totally voluntary program, designed and owned by employees, to promote employee health and to provide confidential assistance to employees, pensioners, and family members when needed for the full spectrum of human concerns and problems (CBN, 1986). The EAP is administered by an elected joint management/labor advisory committee and the services delivered through the plant occupational health nurse. The committee's main efforts in the past three years have been directed to the development of four major reports: (1) Worksite/Work Force Analysis; (2) Health Risks of Employees; (3) Employee Health Survey; and (4) Corporate Health Care Plan. The objective was to rationalize a package of progressive health promotion programs that address environmental and personal health issues and within which the EAP could function as an integral part. Management is currently reviewing the package of recommendations and action is expected shortly. An outside consultant from the Addiction Research Foundation was invaluable in the formulation of these reports.

Program evaluation is an essential ingredient in wellness programming. Such evaluation may occur at three different levels: the process, the outcome, and the impact (Clark, 1986). Process evaluation includes the number of participants, the planned activities, the resources expended, and the type of services provided. Outcomes are used to measure observable change in behavior, attitudes, or knowledge. Impact concerns the total effect of the program including any "spin-off" results. Ongoing workplace wellness programs require continual evaluation and adjustment to meet the changing needs of employees.

At CBN, onsite wellness programs are used more by blue-collar hourly workers, both male and female, and by salaried clerical workers. Employees at the management level do not attend; however, they do utilize the services of the EAP.

Back education programs are attended by persons with a history of back pain, both male and female; 17% of the workforce has attended over a period of five years. Recurrence of back problems has diminished with individual follow-up and assessment. The severity of back injuries has decreased as well. For example, in 1988, there were four employees who lost time from work because of work-related back injuries; the average number of days off work was only four. By comparison, in the preceding five years, an average of four employees per year lost time because of similar injuries; the average number of days off work was 19. This decrease in time lost also reflects changes in the medical treatment of back injuries that promote earlier mobility. The back education program would meet workers' needs more effectively if it were provided at three levels: (1) an ongoing back exercise program to strengthen and condition back muscles; (2) a problem prevention focus for new employees; and (3) the present program for workers with back problems.

Over 50% of employees at CBN, equal numbers of men and women, participate in the annual blood pressure screening programs in their work units. Screening is most effective if easily accessible to workers, either in individual work units or locations or in high-traffic areas such as corridors or the cafeteria. Blood pressure monitoring on a regular basis is carried out on 10% of the workforce, the majority of them women.

At CBN, 36% of employees want to quit smoking (CBN, 1987). Women attend smoking cessation programs in larger numbers than

men and appear to have more difficulty in quitting smoking. For women, smoking is often used to relieve stress and to maintain stable weight. It is a concern while they are pregnant or using oral contraceptives (Health and Welfare Canada, 1988b).

According to the CBN 1987 survey, 52% of employees need to lose weight and 43% need to improve their eating habits. Women in particular face two major risk periods for becoming obese—pregnancy and menopause. Although at CBN more men are overweight (according to the Bodymass Index, a weight-for-height formula), men do not attend weight control/nutrition groups and prefer individual counselling. The weekly weight control/nutrition support group started in 1985 and attracted 17 participants—an average of six persons attending per session during the first year. The group included seven women under 45 years of age with a desired weight loss of 15 to 40 pounds and 11 women 45 years of age or over with a desired weight loss of 10 to more than 100 pounds. Participants attended several or many sessions. Three original members still participate. The usual pattern is to lose weight, then regain when unable to make permanent behavior changes in food consumption and energy output. Those who have more than 50 pounds to lose appear to have more difficulty with motivation and behavior change. Two levels of programming might be more effective—one for those who need to lose less than 50 pounds, and one for those who need to lose more than 50 pounds.

The EAP is well utilized by all levels of employees—an average of 27 clients per year, or 7% of the workforce. Of these, 60% are female and 40% are male. In the year 1987/88, primary concerns for male employees were employee relations and job stress, family or marital concerns, and substance abuse in a "significant other"; females sought help for employee relations, stress and mental health issues, and family or marital problems.

Concern about confidentiality continues to be a major source of worry for employees (CBN, 1987). Inconsistent coverage from the company's insurance carrier for referral treatment of psychological problems is a continuing issue that is currently being reviewed as well.

CONCLUSION

Work-related stress in blue-collar employees is often related to a job that is physically demanding, often mind-numbing or repetitive, or viewed as only a means to an end. Health-threatening conditions may

be treated casually or perceived as just part of the job (Clutterbuck, 1986). Women's stress levels are higher than men's because of the delicate balancing of family and work roles. In addition, a woman may be the primary or solitary care provider for her aging parents as well as a growing family (Callwood, 1987).

Future programming needs at CBN appear to be: (1) the improvement of general health and fitness; (2) the understanding and use of stress management techniques; and (3) the development of skills in interpersonal relationships (CBN, 1988).

For persons considering the implementation of wellness programs at their worksite, the major factors to consider include: needs identification, program planning, use of resources, and cost effectiveness.

"The worksite wellness movement has surpassed the point of being a fad and is being woven into the fabric of the workplace" (Chen, 1988). Successful health promotion programming in the workplace is flexible: it can respond to the needs and interests of the workers and adapt to the unique characteristics of their work environment. Ideally, the focus should emphasize self-responsibility for health care and assist employees in helping themselves to move forward on the wellness continuum (Brennan, 1983).

Assistance with health promotion programming is readily available from a variety of community resources—government agencies, voluntary or non-profit organizations, and private agencies and companies—who will readily provide publications, audiovisual materials, consultation services, and program services. The cost of these resources will vary from almost nothing to very expensive.

The potential cost effectiveness of wellness programs needs to be promoted by those companies interested in it. For example, premature deaths from two leading causes, cardiovascular disease and cancer, can be prevented in large measure by developing health-promoting behaviors such as stopping smoking and eating less fat and more whole grains, vegetables, and fibre. Healthier workers in turn contribute to reduced health insurance payments, decreased absenteeism, and lower disability costs. Workers who are moving towards higher levels of wellness contribute to a work environment that can become increasingly more efficient and profitable for all concerned.

Hopefully, well-considered worksite wellness programs will

continue to evolve at CBN. Their success will depend upon the company's ability to adequately respond to employee needs and the involvement of workers at all levels within the company in their implementation. Management and labor understanding and support remain a critical ingredient in this important process.

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WOMEN IN THE WORKPLACE: Intervention Strategies in a Federal Government Agency

Patricia L. Badiet

In retrospect, the requirement for specialized strategies for reaching women with health and other problems first struck me in my early years as a protection worker with the Ottawa-Carleton Children's Aid Society, where the majority of my clients were women living in poverty. Since then, a variety of opportunities, experiences, and formal training have all contributed to the evolution of my philosophy of intervention with women. My purpose in writing this article is to attempt to explain how that philosophy has evolved, how it shapes my strategy of intervention with women in my current job, and exactly what strategies, both formal and informal, I have employed, with the assistance of other key players, in order to try to meet women's special needs in the context of an Employee Assistance and Employment Equity Program.

EMPLOYEE ASSISTANCE PROGRAMS—A COMPREHENSIVE INTERVENTION STRATEGY

More than 20 years of social work experience and professional training convinced me of the value of applying a more comprehensive approach to solving human problems. For years I have been frustrated by the reality of arriving with too little too late, and I became a strong advocate for strategies that were more preventive in nature and that focused on the primary and secondary end of the problem spectrum. My

formal social work training in a structural approach to problem solving, group work training, and community development experience taught me that any successful strategy needs to work on many levels and requires the interrelated efforts of all the key players.

Those same experiences also sensitized me to the special plight of women. Years of child welfare experience and training in addictions and feminist counselling vividly illustrated the issues of powerlessness, poverty, sexual abuse, family violence, chemical dependency, childcare, single parenting, and the stresses of balancing home and job with minimal supports that many of my female clients faced. My experience as a co-organizer of the first Provincial Conference on Women and Legal Drugs, reviewing the literature on women and chemical dependency, and helping to found the first treatment centre for chemically dependent women in Canada, demonstrated the value of strategies designed to address the particular needs of women.

When both the Government of Canada and other employers in the Ottawa area began to establish EAPs, I was interested and ready for a change. For the past few years I had been supervising a team of social workers and a community development worker in an effort to deliver child welfare services within a community context and with a preventive focus. I recognized that the workplace, a small community in itself, provided an ideal opportunity to reach people with health and other problems at an earlier stage than did the child welfare system.

As I learned more about EAPs, however, I found that although many programs had been successful in helping employees resolve some problems, it was largely at the tertiary end of the spectrum of problem development. Most programs operated in isolation from the rest of the organization and were geared to helping individual employees once the problem existed and their work performance was adversely affected. My past experiences encouraged me to look at other possibilities and to see that many of the principles of community organization and development were also applicable to organizational development. EAPs were well placed, I believed, to become more proactive than tradition dictated and could provide, along with other organizational players, more comprehensive programs to meet the needs of their employee populations. EAPs could develop strategies and approaches that promoted a holistic approach to health and could be more preventive in nature. They could also campaign, within the workplace, for a healthier working environment. Key players to help in this process included senior management,

supervisors, personnel specialists, health professionals, and employees and employee representatives.

THE WORKSITE

When the Communications Security Establishment (CSE) advertised for a professional counsellor to design and implement both an employee assistance and an equal opportunities program for its employees, I seized the opportunity to focus more comprehensively on the needs of people within a particular worksite. While my dual mandate presented particular advantages by allowing me to develop strategies particular to women's needs, among others, I was somewhat apprehensive about the breadth of my responsibilities, particularly as I would be working alone. There were also other advantages. The fact that the organization was relatively small in comparison to other federal government departments (fewer than 1,000 employees at the time of my appointment) made it more conducive to organizational development. CSE, as a separate employer, was outside the federal public service and undertook its own hiring—definitely advantageous from an equal opportunities point of view. Further, an internal joint union/management committee had carefully researched the need for an internal EAP and their recommendations paved the way for its easier entry into the organization.

There were also many challenges. Although CSE was a predominantly civilian organization, its affiliation with National Defence led to a strong military influence, which understandably presented certain obstacles for female employees. Women were seriously underrepresented at the management level and in various technical and nontraditional categories. Furthermore, the highly classified nature of the work required that all employees undergo a rigorous security clearance, and many employees were fearful that disclosure of personal problems might jeopardize their jobs.

In my application of the principles of community organization and development, my first year at CSE was spent getting to know its culture, history, and plans for the future. In order to be effective, I felt it was critical to understand the organization and its people and establish credibility as an organizational resource. I learned who the key people were, what the formal and informal power structures were, who supported the programs, who were opposed. I met with managers, union representatives, personnel specialists, the Health and Welfare Canada nurse, and the employees themselves. Some of these meetings were

formally arranged; others took place in the cafeteria, the hallways, and the parking lot. A bulletin I distributed to all employees, describing my background and answering questions regarding my mandate, stimulated employees to come forward with their concerns. It seemed to be an effective way to launch the program. It soon became apparent that the issues and concerns of female workers were different from those of male workers. Women were struggling with the issues, among others, of balancing home and job, daycare, care of sick children, single parenting, caring for aging parents, working in non-traditional areas, feeling underutilized, and assertiveness.

One of my first steps was to establish a committee comprising a senior line manager, the director of personnel, representatives from both union locals, the HWC nurse, and a volunteer from staff to oversee the policy and direction of the EAP. Having both men and women represented on this joint union/management committee helped to ensure that women's concerns were not forgotten among the many competing priorities. On the bases of a survey of employee interest, and with the committee's support, the HWC nurse and I organized a series of awareness sessions. These were held during working hours and covered a variety of health and lifestyle topics. The sessions helped to publicize the program, destigmatize emotional health issues, and initiate a number of self-referrals.

As the program evolved, I tried to develop dynamic and comprehensive intervention strategies that moved along the continuum of problem development from preventive education to treatment and remediation of serious problems. Programs were therefore geared at the primary level to strategies that would encourage healthy lifestyles within a healthy working environment; at the secondary level to strategies that would encourage early problem solving; at the tertiary level to treatment and counselling once work performance had been adversely affected and serious problems had developed. As I knew women were at high risk for the development of personal or health problems because of their conflicting responsibilities and the high levels of stress they encountered, I also tried to incorporate strategies that were sensitive to their particular needs.

PRIMARY-LEVEL STRATEGIES

Intervention at the primary level has been described as strategies directed at the individual and the organization that encourage healthy lifestyles within a healthy working environment. From my perspective,

a healthy working environment is one that encourages all employees, whether male or female, to achieve their maximum potential.

I quickly learned that participating as a special adviser on committees such as the Health and Safety Committee, the Joint Consultation Committee, and senior management's Personnel Committee was an excellent way to intervene at the primary level and have an impact on the organizational environment. Committee membership enabled me to have input into the development of organizational policies and procedures, obtain management and union support, gain credibility, sensitize the organization to important health and lifestyle issues, and maintain a high profile within the organization.

Through committee membership, I was able to have input into, or influence upon, issues such as the health and ergonomic factors of computerization, smoking cessation, shift work, space, part-time employment, leave for family-related responsibilities, retraining due to technological change, personnel transfers and reassignments, sexual harassment, participation of women, parking policies, flexible working hours, accessibility for the disabled, off-the-job training for support staff, needs of working parents, out-of-town postings, health concerns of pregnant workers, support for noon-hour fitness programs, and showers and change rooms to name a few. Participation on committees quickly earned me the label of the "organization's conscience." While various committee members have been important allies in this role, my input does seem to have helped other players see the implications of important decisions that they might have overlooked because of their specialized focus.

Informal meetings with senior managers, union representatives, and personnel specialists have also been effective in building rapport, raising consciousness, and helping others to see me as a resource for some of the difficult organizational concerns they were addressing. Discussions have included such topics as the needs of working parents, effects of change, needs of older employees, training for female employees, identification of women with advancement potential, and off-the-job training. During the course of these discussions people have often solicited advice or assistance for personal problems they were encountering; an informal meeting seems to provide a less threatening forum for obtaining assistance than calling up to make an appointment for a specific problem, particularly for senior managers.

Workshops, information sessions, and educational campaigns

have also provided excellent opportunities to influence individual and organizational health. Whether independently or in conjunction with other organizational players, our office has played a key role in the development of management training on a variety of topics such as helping workers to cope with stress, with change, and with shift work; the ergonomics of VDTs; communication skills; and identifying the troubled employee. Sessions directed to all employees have included: Managing Your Own Career, Career Advancement and Computer Comfort for Female Support Staff, Managing Stress, Coping with Change, Health Aspects of VDTs, Women as Managers, Financial Planning, Pre-Retirement Planning for Employees and Spouses, Smoking Cessation, and a Food and Body Image seminar. Our employment equity role allowed us to direct some of the seminars to women specifically or at least ensure that the special needs of women were addressed within the content of other seminars. For example, we included issues such as balancing home and job, the superwoman syndrome, and health hazards for pregnant workers within the career, stress management, and VDT courses. Our retirement seminars have addressed the importance of involving both partners in finances and household responsibilities and the special problems facing single retirees, many of whom are women. Ensuring that women were well represented among seminar participants and leaders, and that they were also involved in the planning phase, has been an important aspect of this strategy.

One event, organized under the auspices of our employment equity mandate, was a one-day Women's Conference that helped female employees to identify areas of concern for themselves and management at CSE. The conference's relevance and ultimate success was ensured by management support, the help of an outside consultant who was also a former employee, and a planning group composed of talented women representing various aspects of the organization such as management, union, human resources, clerical support, non-traditional employment, and francophones. Months of careful planning included a questionnaire to female employees to survey their interest and concerns. An opening address by Monica Townson, a leading Canadian author, economist, and feminist, set the tone for the conference. She carefully profiled the reality of the working woman today and the dilemmas women face in trying to carry out their varied and sometimes conflicting roles in the face of obstacles, not the least of which is a workplace predominantly designed on the model of the traditional family of some 30 years ago. Her address was followed by comments of

our CEO and his deputy, who expressed their commitment to the principles of employment equity and their desire to make maximum use of CSE's female workforce.

The day included a number of panels and workshops on topics such as women as managers, women in non-traditional jobs, the staffing process, support staff mobility, balancing home and job, and assertiveness, as well as a film on sexual harassment. A significant number of our employees actively participated in the conference organization by serving as presenters, recorders, and chairpersons of the panels. A specially designed evaluation helped to solicit participants' concerns and recommendations, which were subsequently presented to management for its consideration. Many of these recommendations have since been acted upon. Others continue to guide the direction of employment equity and personnel policy within the organization.

Participants felt that the conference helped them to raise their consciousness, network, and establish a sense of themselves as valuable contributors to the organization's goals and objectives. Many appreciated the opportunity to take a leadership role in the conference, which contributed to feelings of self-confidence and self-worth. Since the conference, several male employees have requested that a workshop be arranged for them to help them better understand the changing role of women and how they can work more effectively with women colleagues. Our future plans include the development of such a seminar series using the Family Service Association of America book entitled *Family\Life Education in the Workplace*. This book will be used as a guide to design a series of lunch-hour modules: "Changes in the Workplace and at Home," "Coping with Dual Responsibilities," "Balancing Work and Family Life," "Time Management and Sensitive Listening Strategies." A recent conference in Toronto, called "New Workplace Synergy: Men and Women Working Together," provided another excellent opportunity for more organizational consciousness raising. Management agreed to send to the conference a team comprising myself, our head of human resources planning, and two senior managers who have since become the Director of Personnel and the Director of Strategic Planning. All agreed the conference was useful in helping to sensitize us to the problems and potential of men and women working together more effectively.

Other information sessions, film presentations, books, pamphlets, and articles written for employee information bulletins have also

been successful primary-level strategies. Some of these have been organized as health and lifestyle campaigns formulated from employee surveys on topics of interest to them. In an effort to sensitize the organization, we have included suggested topics on the surveys that address the special needs of particular target groups: eating disorders (food and body image), balancing home and job, coping with aging parents, shift work, AIDS in the workplace, sexual harassment, assertiveness, and parenting, to name a few. Literature displays, bibliographies, lists of community resources, and posters have been integral components of the campaigns and seminars. Other campaigns have been tied into community or national events such as Fitweek and drug awareness, mental health, heart, nutrition, and women's weeks.

Fitweek Canada provided another ideal opportunity to intervene at the primary level within the organization. With management support, a coordinating committee made up of female and male employees oversaw the organization of the week's events, launched by a Sneaker Day walk and picnic at lunchtime and concluded by relaxation exercises largely attended by the Fitweek organizers! Active participation by senior managers gave visible proof to employees of their support for fitness activities. Women were also well represented in leadership roles in the organization of the events, which ensured female participation. Several employees have reported that the week's events inspired them to develop a personal fitness plan. Another committee has been established to coordinate next year's Fitweek.

Intervention around chemical dependency issues has been particularly challenging because of associated stigma. We have found the indirect approach to addressing chemical dependency issues to be far less threatening than actual presentations on the subject. Given that 40% of the population is estimated to have family members or peers who are problem drinkers, we have tried to disseminate this information in our stress and employee orientation briefings. Highlighting the disease aspects of chemical dependency and the associated risk factors of a family history of drinking problems has been useful in lessening the stigma. We have also touched on the telescoping nature of the disease with women, the effects on children, and the special concerns related to legal-drug dependency. Supervisors, union representatives, and employees are encouraged to consult with our office on ways to deal with and confront chemical dependency problems in others. Our supervisory training includes role plays in which women portray a manager and an employee with a dependency on tranquillizers.

An annotated bibliography of our growing library has been circulated throughout the organization. Many of the books address women's issues such as the working mother, the single parent, two-career families, women and finances, stress, assertiveness, eating disorders, parenting, widowhood, and women as managers. Our circulation of pertinent articles and seminar feedback to senior managers has stimulated requests for special briefings on topics such as managing change and the health aspects of shift work. Whatever the methods employed, all have been effective in initiating self-referrals to our EAP for information, brief counselling, or problem assessment and referral to organizational or community resources for specialized help. As well, these activities have assisted managers in identifying and seeking help for employee concerns, whether for individual or collective issues. Union representatives and other employees have also been encouraged to seek help in dealing with family problems or with concerns about colleagues.

SECONDARY-LEVEL STRATEGIES

Intervention at this level most often comes as a result of self-referrals (90% of all referrals) stimulated by our efforts at the primary level, and service has consisted of brief supportive counselling or early problem-solving intervention and management and union training. Although women constitute approximately 30% of our workforce, more than 50% of our referrals are women.

In considering the needs of women among our client population, development of our own skills has been critical to the effectiveness of our intervention. Our experience bears out the fact that women often present in a very confused way and are often misdiagnosed as a result. A feminist counselling approach that builds upon their strength and competence and helps them to see the conflicting demands in their lives seems to be the most helpful method of intervention. Women often feel guilty about not being able to accomplish more, and they require validation and support in counselling. Maintaining sensitivity to low self-esteem, not reinforcing guilt or blame, and not creating dependency is critical. These aspects are particularly important when dealing with a chemical dependency problem, as a woman frequently is unaware that she is chemically dependent. The male confrontation model is often inappropriate for women, as it can reinforce shame. As a matter of course, it is important to explore for sexual abuse experience, battering, premenstrual syndrome, stress management, and chemical de-

pendency. We have also found that a large number of clients are adult children of alcoholics who have never identified, on a conscious level, chemical dependency as the problem in their families. Education on how this is affecting their current lives often relieves guilt and tension. Eating habits and setting aside time for themselves are often areas of particular neglect among women.

Trying to empower female clients to take control of their lives, whether at home or at work, is an important focus of the intervention. Whenever appropriate, we try to encourage women to develop career, family, and personal goals that will facilitate this process. We try to help them become more assertive about their skills and abilities, which they often minimize, and encourage them to become more proactive in their career development by networking. Self-help groups are an effective way to empower women, lessen their guilt, and help them to see the collective issues women confront. Encouraging women to take leadership roles within the organization, the union, and committees has also been an important aspect of the intervention.

During our management and union training sessions, our focus has been to assist managers with early problem identification and to encourage them to consult us whenever they see a potential problem developing. This approach has proven to be particularly helpful for women, as managers are often reluctant to confront women and often dismiss developing problems as being related to women's cycles, family responsibilities, or lack of motivation or interest in their careers.

TERTIARY-LEVEL STRATEGIES

When problems require more than a few appointments to resolve, we try to link our female clients to a network of counselling, resource, and treatment centres that we know are sensitive to women's needs. If there is an identified performance problem, our counselling sessions with supervisors help them to specify the problem and avoid minimizing it, to deal with their own feelings of frustration, helplessness, and inadequacy and fears of harassment accusations, and to prepare their documentation and the motivational interview. We have found that it is equally important to sensitize them to women's issues and explore their expectations of women—for example, how they will handle tears or anger and how they can avoid reinforcing shame. Union representatives who may be present during the interviews need similar support if they are to be helpful to the employee.

Once women have recovered self-esteem and resolved personal, health, and family problems, they have more energy to focus on their careers and other concerns; and the EAP is well placed to provide the necessary support and guidance to tackle such issues effectively. Liaison with outside resources is important for follow-up counselling. Supervisors, union representatives, and personnel specialists also welcome any support and guidance we provide. Acknowledgment of a job well done and their role in helping the employee, whether or not the particular intervention is successful, is appreciated. Clarifying the nature of intervention as a process rather than an event helps to avoid discouragement.

SUMMARY

Although I originally resisted the request to put pen to paper and explain the why, what, and how of my intervention strategies for reaching women in the workplace, writing this has proven to be a very useful process. It has given me the opportunity to step back and analyse what I have been doing, for the most part instinctively, over the past few years. In hindsight I have been driven by the belief that I would be more helpful by trying to influence the organization to consider its employees as an important resource and to help it develop the means to maximize this potential within a healthy working environment, rather than restricting my interventions to helping employees once they were sick and injured and stumbled or were pushed through my door. Needless to say, day-to-day crises, conflicting demands, and a busy work schedule have not always allowed time for the careful planning that a fully comprehensive and integrated strategy requires. We have tried to do the best we could within the limitations of our resources.

During my eight years with CSE, the organization has grown significantly and undergone a number of changes. Although the overall representation of females in the employee population has remained static, their distribution has changed. More women are now employed at the management level and in the more technical and non-traditional areas of the organization. Today female employees can aspire to most positions in the organization and have an environment more supportive of their needs. Many of the male managers have spouses with careers and share the responsibility for childcare. Many are no longer able to spend long hours at work — the practice when women assumed the major responsibility for childcare — and have to leave on time to pick up children at daycare. As well, more men are now asking for part-time

employment in order to help in the care and nurturance of preschool children.

CSE management has also demonstrated a commitment to consider the needs of its female workforce as a priority among many of the challenges facing the organization. Recently, they allocated the necessary resources to undertake a thorough workforce analysis and employment systems review. This will eventually lead to more comprehensive human resource planning that incorporates special measures to increase the representation of the employment equity designated groups. Two years ago, in order to ensure the continuity and ongoing effectiveness of the EAP and the employment equity program, management also allocated two additional positions to our office, an expansion that has helped us to provide a more comprehensive service.

If I am asked to cite those elements that have proven to be most critical to the success of our programs, first and foremost would be management and union support, followed closely by a high-level reporting relationship outside of the personnel structure. Establishing credibility as an organizational resource and obtaining the trust of the organization and an adequate budget for educational programs are also crucial. Maintaining a special focus on, and a sensitivity to, women's special needs is paramount if we are to be effective in reaching them. At CSE our joint responsibility for both the EAP and employment equity has helped us to do this.

MAKING WORKSITE LEADERS AWARE OF HOW EAPS CAN BETTER SERVE FEMALE EMPLOYEES

VIRGINIA CARVER AND CHARLES PONÉE

In 1986, the Addiction Research Foundation (ARF) hosted a symposium on "Women, the Workplace, and Employee Assistance Programs" for EAP personnel in Ottawa-Carleton worksites.

Co-sponsored by Metropolitan Insurance Companies and the Regional Municipality of Ottawa-Carleton, the event was designed to draw attention to the special needs of the female employee and how these can best be addressed through EA programming—an appropriate undertaking in recognition of International Women's Week, 1986!

The Regional Municipality of Ottawa-Carleton has a population that is 52% female and an above-average female labor force participation rate. This area also has numerous active EAPs in both the public and private sectors. Nevertheless, there is continuing concern that such programs do not adequately address the needs of female employees, particularly those with more serious health problems such as substance abuse.

Overall, the goal of the symposium was to have EAPs better meet the needs of the female employee. The specific purpose was to increase the knowledge and awareness of EAP coordinators and advisory com-

mittee members in area worksites, with two themes: ways to involve women in the planning and implementation of EAPs; and how to effectively reach the female employee through EAPs.

The budget for the symposium was a mere $300. Low cost was considered important in order to ensure that this event could be easily replicated.

THE AGENDA

It was established that the key items to be addressed in the symposium would be:

- Profile of working women in today's world
  - -Who are the women in the workplace?
  - -Who are the women who may require EAP services?
- Ways to involve women in planning and implementing EAPs
  - -Why EAPs are not reaching women
  - -Why and how to involve women in the process of establishing an EAP
  - -How to make EAPs more sensitive to women's needs
- Role of women union representatives on EAP committees
  - -Role of the union
  - -How unions ensure that EAPs are sensitive to women
  - -What the advisory committee needs to know
- Reaching the women at your worksite
  - -How do you assess the needs of your female employees?
  - -What kinds of programming do you develop to meet those needs?
  - -How successful are you in reaching women employees?

In developing the agenda, it was decided that the symposium would be an introduction to the issue of women and EAPs with the hope that participants would identify topics for subsequent workshops. The format of the afternoon moved from the general to the specific, covering the four key areas noted above and concluding with a wrap-up and evaluation of the event.

WOMEN, THE WORKPLACE AND EMPLOYEE ASSISTANCE PROGRAMS

AGENDA

12:00 noon - 1:00 p.m.	REGISTRATION/BOX LUNCH EAP FILMS AND DISPLAY TABLE AVAILABLE FOR VIEWING
1:00 - 1:05 p.m.	WELCOME AND INTRODUCTORY REMARKS *VIRGINIA CARVER, CONFERENCE CHAIRPERSON*
1:05 - 1:20 p.m.	SHAPING THE FUTURE FOR WOMEN: CRITICAL INTERVENTIONS, *FREDA PALTIEL, SENIOR ADVISOR, STATUS OF WOMEN, HEALTH & WELFARE CANADA*
1:20 - 1:55 p.m.	PROFILE OF WORKING WOMEN IN TODAY'S WORLD, *MARY HUGESSEN, THE OTTAWA PASTORAL CENTRE*
1:55 - 2:00 p.m.	STRETCH/BREAK
2:00 - 2:30 p.m.	HOW TO BUILD WOMEN INTO YOUR EMPLOYEE ASSISTANCE PROGRAM *CAROL ANN CURNOCK, METRO TORONTO REGION EAP CENTRE, ADDICTION RESEARCH FOUNDATION*
2:30 - 3:00 p.m.	ROLE OF THE UNION REPRESENTATIVE *CYNTHIA WISHART, CANADIAN UNION OF PUBLIC EMPLOYEES*
3:00 - 3:15 p.m.	BREAK
3:15 - 4:45 p.m.	PANEL PRESENTATION AND DISCUSSION: REACHING WOMEN AT THE WORKSITE *LINDA IRVING, SOCIAL WORKER REPRESENTING: REGIONAL MUNICIPALITY OF OTTAWA-CARLETON* *MARY O'BRIEN, DIRECTOR, HEALTH SERVICES, CARLETON UNIVERSITY* *PENNEY PRUD'HOMME, NATIONAL COORDINATOR, EMPLOYEE ASSISTANCE PROGRAM, PUBLIC WORKS CANADA* *MARNIE COLLINS, PLANT NURSE, RENFREW PLANT, MITEL CORPORATION* *CHAIRPERSON: SUSAN THOMAS-GILMAN, WIFE ASSAULT CONSULTANT , NATIONAL CLEARINGHOUSE ON FAMILY VIOLENCE, HEALTH & WELFARE CANADA*
4:45 - 4:50 P.M.	BREAK
4:50 - 5:15 P.M.	WRAP-UP AND EVALUATION *PAT BADIET, COORDINATOR, COUNSELLING AND ADVISORY PROGRAM, COMMUNICATIONS SECURITY ESTABLISHMENT*

HOW WE DID IT

The Planning Committee

The first task was to strike a small (four or five persons) planning committee, which included ARF staff and community representatives. Ultimately, ARF members consisted of a staff person from the local ARF centre with expertise in women's issues and the Regional Employee Assistance Program Consultant. A rough draft of the purpose and objectives was developed to assist in the process of recruiting community members to the planning committee and approaching organizations to co-sponsor the event. Community members consisted of a worksite EAP coordinator who also had expertise in women's issues and addictions and an occupational health nurse who, as well as representing one of the sponsoring organizations, had considerable experience in organizing similar events.

Sponsorship

Sponsorship was obtained from two organizations with which local ARF staff had longstanding working relationships. Metropolitan Insurance Companies provided a financial contribution to cover the travel costs of speakers, space and equipment for the symposium, and extensive staff time to the planning committee, as well as covering the cost of a variety of other items such as beverages for the break and mailing costs. The Regional Municipality of Ottawa-Carleton undertook the layout and printing of a special brochure on women and EAPs and the typing of the workshop proceedings document. In addition, Regional staff were a resource to the Planning Commitee.

A local catering company provided box lunches at cost.

Presenters

Speakers were chosen who had expertise in women's issues and/or EAPs, and who were known and credible to the participants. It was decided that all speakers would be women in order that the broad message underlying the symposium would be demonstrated in fact.

Financial constraints prevented us from providing a bilingual event. However, several of the speakers were fluently bilingual and could respond to questions from the audience in either English or French.

Participants

It was decided to limit the total number of participants in order to maximize opportunity for discussion. The final participant list comprised 30 people, of whom 19 represented government agencies. In addition, there were 10 presenters and five Planning Committee members.

An invitation was type-set and mailed by staff at Metropolitan Insurance Companies to approximately 200 Ottawa-area EAP coordinators/committee members who in the past had used ARF EAP services. A response date was set for approximately three weeks prior to the symposium date so that the planners would have time to develop a "back-up" list.

Kit Materials

The information kits provided to all participants included the symposium agenda for the afternoon, biographies of presenters, a list of participants, a list of Planning Committee members and staff, ARF EAP brochures, and a special brochure entitled *Women, The Workplace and Employee Assistance Programs* developed for the symposium. In addition, each participant was provided with a pen and note pad and an evaluation form.

It was also decided to make available to participants four key articles that reflected the content of the day. These articles were included in the information kit or displayed on the resource table, along with other resource materials from ARF, Health and Welfare Canada, and Metropolitan Insurance Companies, a local directory of addiction services, and flyers from the women's addictions agencies. A video entitled *A Fighting Chance*, produced by ARF in collaboration with the Department of National Defence (Civilian) and the National Film Board, was available for viewing prior to the symposium.

Evaluation

The evaluation form, completed at the end of the workshop, contained the following questions:

1. What did you find most useful in this afternoon's symposium?
2. What did you find least useful in this afternoon's symposium?
3. Can you suggest any improvement to the symposium?
    a) Content

b) Format

c) Organization

d) Setting

4. How do you plan to incorporate information from this afternoon's symposium into your employee assistance programs?
5. Would you like further workshops on how employee assistance programs can address the needs of women? Yes___ No___

   If Yes;

   - What topics would you like addressed?
   - What format (i.e. information giving/skill building)?
6. Do you have any suggestions for other workshops in the EAP area?
7. Are there other ways the Addiction Research Foundation can be of assistance to you?

THE RESULTS

This modest but unique event generated considerable interest and excitement in the Ottawa-Carleton EAP community, and both formal and informal feedback was extremely positive. It appears that the symposium met its objectives in that the participants became more knowledgeable about, and aware of, ways in which to involve women in the planning and implementation of EAPs and how to effectively reach female employees through such programs.

A number of participants have begun to apply at their worksites what they learned at the symposium. Further, this symposium generated several other similar events (e.g., in Kingston and Ottawa). The success of this first event and of subsequent events in Ottawa and Kingston demonstrated that the issues related to working women are a major concern.

The latter events drew on a wider audience than just EAP coordinators and demonstrated both the need for awareness raising and participants' desire for specific skills and approaches to women's concerns, individually and collectively, that participants could apply in their own lives and at their places of work.

RESOURCE MATERIALS

ADDICTION RESEARCH FOUNDATION

Assisting employees with problems affecting job performance (pamphlet), 1984.

Can I take this if I'm pregnant? (brochure), 1984.

Coffee, tea, & me, and... (brochure), 1985.

Drug and alcohol information line (brochure), 1988.

EAP folder, 1984.

A fighting chance (videotape). Coproduced with the Department of National Defence and the National Film Board, Ottawa, 1985.

Here's a hot tip for your small business (pamphlet), 1984

Management and the employee assistance program (pamphlet), 1984.

ONSITE (quarterly EAP publication, no longer available).

Questions and answers about employee assistance programs (pamphlet), 1984.

Setting up an employee assistance program (pamphlet), 1984.

The troubled employee in your small business (pamphlet), 1984.

The union and the employee assistance program (pamphlet), 1984.

Women and alcohol (statistical information sheet), 1981.

Women and drugs (statistical information sheet), 1981.

Women and prescription drugs (pamphlet), 1980.

Your employee assistance program (pamphlet), 1984.

HEALTH AND WELFARE CANADA

Helping children cope with family breakup (pamphlet produced by the Academy of Psychology, Ottawa, in collaboration with the Mental Health Division, Health and Welfare Canada), 1985.

Let's talk about...smoking (pamphlet), 1985.

Women and alcohol (pamphlet), 1985.

HEALTH AND WELFARE CANADA: CLEARINGHOUSE ON FAMILY VIOLENCE

Another bibliography—Men who batter, 1985.

The family violence film collection (produced with the National Film Board of Canada), 1985.

Transition houses and shelters for battered women in Canada, 1985.

Vis-à-vis (newsletter), 1983/85.

LABOUR CANADA: WOMEN'S BUREAU

Changing course (pamphlet), 1983.

Do you know where you are going? (pamphlet), 1984.

A fair trade (pamphlet), 1983.

Times have changed... you've changed (pamphlet), 1983.

Women in the labour force. Part 1: Participation; Part 2: Earnings gains; Part 3: Facts and figures, 1984.

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